Country Operational Plan

(COP/ROP) 2021

Strategic Direction Summary

Date: 05-25-2021

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1.0 Goal Statement

In COP20, PEPFAR Kenya's goal was to support Kenya's effort to achieve and sustain HIV epidemic control through a tiered county public health response that ensures high community-level viral suppression, reduces HIV infections across all populations, and accelerates national and county government ownership. In COP21, PEPFAR Kenya will continue to build upon the strategies of COP20 to rapidly adapt Kenya's programs through client-centered solutions essential to ensure continuity of HIV prevention and treatment services in the context of COVID-19.

Efficiency, county leadership, client-centered service delivery, root cause analysis, and strong partnership will therefore continue to govern COP21 implementation. Resources will be prioritized based on need, guided by the most updated HIV estimates. The 40 counties receiving direct support will be categorized into 3 clusters to guide the case finding approach: high (≥80%), medium (70-79%), and low (<70%) antiretroviral (ART) coverage. Specific interventions for ART scale-up will be driven by granular site-level data on burden, coverage, unmet need, yield, linkage, and net ART growth. Analysis will also include a review of incidence data to guide scale up for efficient and effective HIV prevention interventions including pre-exposure prophylaxis (PrEP), Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS), voluntary medical male circumcision (VMMC), and key population (KP) programs.

Working in collaboration with national and county governments, PEPFAR Kenya will support implementation of key enabling policies for case finding, treatment, prevention, orphans and vulnerable children (OVC), and health systems support. At the program level, PEPFAR Kenya will build on successful ART scale up and viral load (VL) coverage and suppression, as well as safe and ethical index testing for case identification to institute a road map toward epidemic control and self-reliance. Persistent programmatic gaps such as low DREAMS program completion rates, suboptimal retention and linkage to ART, attrition from care for PBFW and high mother-to-child transmission (MTCT) of HIV, and poor performance in some counties will be addressed. A public health approach to case identification, utilizing recency testing to define and respond to geographic "hot spots," will be adopted.

In FY21 Q1, PEPFAR Kenya reported improved VL suppression at 95%; however, there was a reduction in overall VL testing uptake and VL suppression among children and adolescents remained suboptimal. COP21 will focus on closing the gaps in VL uptake and improving suppression among these populations while maintaining the successful strategies used in adults. PEPFAR will forge strong partnerships with county governments so efforts can be focused on bringing back those experiencing interruption in treatment, as well as improving continuity of treatment for clients on lifelong treatment, including a focus on young and healthy individuals at higher risk of treatment interruption. Through root cause analysis, the program will employ both proactive and reactive measures to

ensure minimal missed appointments and rapid re-engagement into treatment for those falling out, including appropriate redeployment of human resources for health (HRH) and use of technology.

Results from the DREAMS Recency Study found younger adolescent girls and young women (AGYW) (aged 15-19 years) and non-DREAMS participants had a higher proportion of recent infections among new HIV diagnoses compared to older AGYW (aged 20-24 years) and DREAMS participants. The study also demonstrated the feasibility of conducting Asanté™ HIV-1 Rapid Recency® Assay. Kenya is in the process of scaling national HIV recency surveillance to all counties, prioritizing counties which are the highest contributors to HTS_POS and counties which are exhibiting a surge in new infections. Recency data will continue to be incorporated into data use and public health action planning at national, regional, and county levels to target prevention and testing interventions in geographic "hot spots."

In order to sustain the gains made in the HIV epidemic response, PEPFAR Kenya will continue to build on systems investments at county level through collaboration between the County Health Management Teams (CHMTs) and designated county lead and systems support implementing partners (IPs). Through this collaboration, county transition plans will be finalized and implemented to enhance ownership, sustainability, and the journey toward self-reliance. There will be engagement at various levels to ensure recognition and regularization of community-level cadres and formalization of task shifting and sharing of standards.

To further support national and county governments in their journey toward self-reliance, PEPFAR Kenya will continue to engage all stakeholders to support efforts toward epidemic control. As with COP20, stakeholders have provided invaluable input into the conceptualization, development, and implementation of the COP21 process as well as during the quarterly PEPFAR Oversight and Accountability Response Team (POART) and key TWG meetings in spite of COVID-19 restrictions. Alongside exemplary commitments by the Government of Kenya (GOK), Global Fund (GF), United Nations family (UN), private sector, and civil society (CSOs) and faith-based organizations (FBOs), PEPFAR Kenya will continue to work closely with all stakeholders during the implementation of COP21 to ensure that the complementary efficiencies and priorities set forth in this Strategic Direction Summary (SDS) lead to epidemic control.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Based on the 2019 population census, Kenya's population is 47.6 million, 50.5% of whom are female and 39% (18.5 million) of whom are children aged <15 years (KPHC, 2019). Adult HIV prevalence is 4.5%, with substantial geographic variation ranging from 0.2% in Wajir County to 18.5% in Homabay County (County HIV Estimates, 2020). It is estimated that there are 1.5 million people living with HIV (PLHIV), of whom 106,000 are children aged <15 years (County HIV Estimates, 2020). Females are disproportionately affected, with a prevalence more than double that of men, at 6.6% versus 3.1% respectively (KENPHIA, 2018). In 2020, it was estimated that there were 41,416 new HIV infections, representing an adult HIV incidence of 0.12% (County HIV Estimates, 2020) compared to 0.14% in 2018 (KENPHIA, 2018). AGYW aged 15-24 years contributed to 25% of all new HIV-infections. HIV-associated mortality continues to decline, with an estimated 20,997 deaths due to HIV in 2020. Although both annual deaths among PLHIV and new HIV infections are decreasing, the incidence-mortality ratio is still >1 with greater new infections than deaths due to all causes annually among PLHIV (Figure 2.1.4).

Kenya has made significant progress toward HIV epidemic control. By the end of December 2020, there were 1,201,889 PLHIV on ART in PEPFAR-supported facilities across the country (Figure 2.1.3). Based on the most recent national survey, community-level viral suppression among adults aged 15-64 years was 72.9%, while 79.5% of those who were tested positive knew their HIV status, 96% of those with known HIV status were on antiretroviral treatment (ART), and 90.6% of those on HIV treatment had suppressed viral load (VL) results (KENPHIA, 2018). Comparatively, among children aged 0-14 years, 78.9% with HIV infection knew their status, 93.2% of these were on ART, and 67.1% of children on ART had a suppressed VL (Table 2.1.2). This cascade shows that, in Kenya, the biggest gaps are in case identification among all age groups and VL suppression among children. Notably, there is substantial variation in ART coverage across counties, ranging from 9% in Wajir county to 128% in Vihiga county (County HIV Estimates, 2020).

COP21 will continue to build on the strength and strategies of COP20 to accelerate progress toward HIV epidemic control. The overarching shift will be to tailor strategies based on programmatic, survey, and Spectrum data, both by sub-population and by county.

The program has tailored strategies to ensure that each county not only increases ART coverage based on Spectrum 2020 estimates, but also stays on a trajectory toward community-level suppression through client-centered approaches that not only keep recipients on treatment but also addresses individual-level needs.

Service Delivery Shifts as Tailored to Cascade

Cascade	Service Delivery Shifts
Testing and case identification	● Implementation of a public health approach through recency and case-based surveillance for high and medium ART coverage counties ● Continued efforts to optimize testing efficiency through eligibility screening as well as symptom and risk-based testing ● Robust emphasis and mentorship on implementing safe and ethical index testing through a voluntary and rights-based approach (e.g. ensuring the 5 Cs: consent, confidentiality, counselling, correct results, and connection referral and linkage)
Linkage to treatment	● Proactive case management, increasing HRH investment in linkage officers and repurposing some of the HIV testing services (HTS) counselors to proactively focus on linkage to treatment ● Proactive linkage of treatment of infants identified through EID
Durable engagement and continuity of treatment	● Shift in the policy environment to enable recipients of care to have options on multi-month dispensing (MMD) of up to 6 months ● Increased external drug pick-up options including through the private sector using decentralized drug delivery (DDD) ● Increased coverage of and support to responsive mobile digital platforms that enhance continuity of treatment through appointment reminders building on existing Ministry of Health platforms ● Engagement of local communities, FBOs, and PLHIV, KP, and AGYW networks to address stigma and improve continuity of treatment ● Repurposing of HTS HRH investment for continuity of treatment ● Continuous analysis of data—especially TX_ML data—to identify age- and population-specific causes of disengagement from care to reduce interruption in treatment ● Return to care packages tailored to address the recipient of care's individual needs
Viral load suppression	● Optimization of treatment regimens to more efficacious and durable regimens: dolutegravir (DTG) for adults and children >20kgs, and pediatric DTG (pDTG) for infants and children >3kg or >4 weeks of age ● Engagement of local communities, FBOs, and local social services and networks to address stigma and improve treatment coverage and continuity of treatment for children ● Deliberate shift to ensure caregiver literacy for those with very young children is in place and implemented with fidelity ● Full-scale implementation of peer-led and asset-based interventions to increase VL suppression among adolescents including Operation Triple Zero (OTZ), and family-centered approaches such as the Jua Mtoto Wako initiative between clinical and community (OVC) partners.

2.1.2 Maternal-to-Child Transmission (MTCT)

An estimated overall MTCT rate of 11% (Spectrum 2020 estimates) is unacceptable. Elimination of MTCT (eMTCT) remains a key goal of Kenya's HIV epidemic response. Of women attending first antenatal care (ANC 1) in FY20, 99% knew their HIV status and 99% of those who were identified as HIV positive initiated ART. Early infant diagnosis (EID) coverage improved due to enhanced post-natal HIV retesting and HIV-exposed infant (HEI) identification at immunization clinics. Of the 55,141 EID tests, 75% were

tested at the recommended age of <2 months, 1,022 (2.05%) were identified PCR positive, and 89% were linked to treatment.

Despite these good indicators, the estimated overall MTCT rate remains high at 11% (Spectrum 2020 estimates). A review of program data indicates that 50% of infant HIV infections occurred in 8 high burden counties and a further 30% in medium burden counties, with MTCT of 9% - 15% and sharp increases experienced in ASAL counties (draft 2021 estimates). Based on the Spectrum estimates, 95% of infant HIV infections were either due to: 1) mothers dropping off ART (47%, thus highlighting the importance of improving continuity of treatment in PMTCT programs); 2) acquiring HIV infection during the pregnancy or breastfeeding period (23%); 3) not initiating ART (16%); or 4) initiating ART late (9%). Based on the national positive infant PCR audit, while only 30% of HIV positive pregnant or breastfeeding women (PBFW) were newly diagnosed with HIV, they contributed to 63% of infant HIV infections diagnosed in the EID program. Additionally, young women, those who did not attend ANC, and those who started ART late (e.g. during the postnatal period) were all at increased risk of MTCT.

Understanding contextual factors and community engagement will be critical in tailoring interventions in COP21. The PEPFAR Kenya PMTCT program is aligned to the GoK's EMTCT strategic framework, and seeks to address stigma and reduce discrimination in facilities through mentor mothers, peer educators, and targeted community support toward treatment continuity. PEPFAR Kenya will engage other stakeholders to strengthen the extensive community support that was discussed during the COP planning process.

The program will continue to utilize the national eMTCT framework launched in 2017 which provides an opportunity to close these gaps in COP21. Specific strategies informed by root cause analysis will be implemented to improve continuity of treatment and viral suppression of PBFW on ART, as well as early identification and linkage to follow-up of HEI. This will include strengthening referrals and linkage to OVC programs for additional support. In addition, women at high risk of HIV infection including PBFW will be prioritized for prevention interventions such as PrEP and layered DREAMS interventions. Improving EID coverage will remain a priority in COP21, with an increased focus on early testing of HEI who are aged <2 months through enhanced continuity of treatment, post ANC 1 retesting and referral, and HEI screening at immunization.[1]

2.1.3 Orphans and Vulnerable Children (OVC) and Children Living with HIV/AIDS (C/ALHIV)

In COP 21, the OVC program continues to align with HIV burden and OVC unmet need. The OVC program will pivot to work in 25 counties (of which 21 are high burden counties and 4 medium burden counties) from 39 counties in COP20. The OVC program will continue to scale up and offer opportunity for enrolment into the OVC program to

[1]The program began reporting on the correct denominator in FY19, based on MER Indicator Reference Guide Version 2.3 FY19

C/ALHIV, pregnant adolescents, breastfeeding young mothers and HEIs, children of KP, and children who have experienced any form of sexual violence. This means scaling up the number of OVC receiving OVC_Comprehensive from 46% (330,813) in COP20 to 62% (396,866) in COP21 and reducing the number of OVC_Preventive from 30% (216,000) in COP 20 to 10% (66,800) in COP21 and DREAMS beneficiaries (aged 9-17 years) from 23% (164,559) in COP20 to 28% (136,742) in COP21.

The OVC and clinical programs have intensified collaboration over the years, thereby seeing continued increase in the number of C/ALHIV being offered opportunity for enrolment into the OVC program. The program has also witnessed intensified identification, tracking, and referrals for biological children of PLHIV and biological siblings of C/ALHIV. This has been made possible through MOUs between clinical and OVC IPs. COP21 will see the start of implementation and monitoring of the OVC/PMTCT SOP and checklist developed by the OVC and PMTCT interagency teams in COP20. The SOP will enable both the PMTCT and OVC programs to identify, track and refer pregnant adolescents, breastfeeding adolescent mothers, and HEIs both from facility and community levels. From this structured collaboration, it is anticipated that there will be an increase in enrolment of adolescent young mothers into the OVC program, increased linkages to DREAMS for the HIV negative adolescent pregnant and breastfeeding mothers, increased monitoring and documentation of progress on uptake of interventions for HEIs, VL for their adolescent mothers, and HIV testing for the AGYW.

The package for C/ALHIV is age appropriate and is based on a case plan developed by the child's family and case worker. The intervention packages range from 1) nutritional support; 2) birth certificate acquisition; 3) education subsidies, levies and fees; 4) disclosure; 5) treatment adherence support; 6) linkage to psychosocial support groups; 7) home visits; 8) transport support to appointments; 9) peer support group meetings; 10) parenting skills; 11) household economic strengthening activities for C/ALHIV caregivers; and 12) linkage to social safety net programs.

With leadership and guidance from the Department of Children Services, the OVC program continues to report through the GOK Child Protection Information Management System (CPIMS). To continue to advocate for increased OVC funding from national and county governments, the program will intensify use of data analytics and carry out evidence-based reviews. Collaboration and coordination of activities by both Department of Children Services and the OVC program will ensure transparency and leveraging of resources from stakeholders who are also implementing various social safety net programs. Leveraging these stakeholders' investments and resources (e.g. GOK, UNICEF, FCDO, WB, etc.) will enable increased advocacy for resources—both technical and financial—from county governments to support OVC within their respective counties.

2.1.4 Adolescent Girls and Young Women (AGYW)

In order to address the continued high HIV incidence among AGYW, Kenya implements the DREAMS program through the provision of evidence-informed, age-appropriate layered services for HIV prevention, as well as prevention and response to violence among AGYW aged 9-24 years. In COP21, the program will increase ward coverage within the current DREAMS counties (Homabay, Siaya, Kisumu, Migori, Nairobi, Kiambu, and Mombasa) targeting 321,241 unique AGYW and an additional 54,151 boys and girls who will receive a single school-/community-based violence and HIV prevention evidence-informed intervention. The PEPFAR DREAMS program will work closely with the Ministry of Health, NACC, the Department of Children Services, GF recipient partners, and other stakeholders to discuss, explore, and facilitate existing opportunities for saturation and geographic expansion.

2.1.5 Voluntary Medical Male Circumcision (VMMC)

Since 2017, Kenya has been working toward ambitious annual targets to achieve VMMC prevalence of 80% in males aged 15-29 years while expanding services for boys aged 10-14 years. With the available evidence that conventional surgical circumcision among boys aged <15 years is associated with a higher risk of glans injuries, urethral fistula, and other adverse events, VMMC services are now limited to men aged ≥15 years. The new policy excluding boys below 15 years from VMMC eligibility under PEPFAR support has been implemented in Kenya from COP20. With this shift, the annual program target declined from 200,000 in COP19 to 54,884 in COP20 and will be maintained at 55,023 in COP21. The drop in annual targets is matched to uptake of services by older males.

In COP21, VMMC service delivery in Kericho county will be transitioned from PEPFAR support to the Ministry of Health. This is in addition to Nakuru and Busia counties which were transitioned to the Ministry of Health in COP20. All the three transitioned counties have achieved 80% overall circumcision prevalence among men aged 15-64 years, although there remain focal areas of low prevalence in these counties inhabited by non-circumcising ethnic groups. The transitioned counties will continue to receive technical and non-service delivery support from PEPFAR in COP21 to sustain the gains already made through previous investments. Six counties with MC coverage below 80% (Turkana, Kisumu, Homabay, Siaya, Migori, Nandi) will receive comprehensive PEPFAR funding in COP21 (Table 4.8.2). Review of county prioritization for VMMC will continue to be informed by MOH data from ongoing VMMC data validation for annual estimates.

2.1.6 Key Populations (KP) and Vulnerable Populations

Kenya's National AIDS and STI Control Program (NASCOP) has recognized the following categories of KP in Kenya: female sex workers (FSW), men who have sex with men (MSM), the transgender population (TG), and people who inject drugs (PWID). In recognizing their HIV prevalence and incidence, along with their vulnerability and contribution to the national HIV epidemic, Kenya has categorized fisherfolk and populations in prisons and other enclosed settings as high-risk priority populations deserving tailor-made HIV programming. In 2021, the NASCOP committee of experts changed the name 'priority

populations' to 'vulnerable populations', a category which—in addition to fisherfolks and prison populations—also includes military, truckers, and discordant couples.

Over the years, KPs have had high HIV prevalence rates, ranging from estimates of 18.2% among MSM, 29.3% among FSW, and 18.3% among PWID (IBBS, 2011). Fisherfolk in the Great Lakes region of western Kenya constitute a vulnerable population with an estimated 23.4% HIV prevalence (KEMRI Asembo Fisherfolk IBBS, 2016). These demographic and epidemiological data are summarized in Table 2.1.1 and Table 2.1.2 below.

In 2018, the first phase of a PEPFAR-funded size estimation activity led by NASCOP provided updated estimates of KP sizes based on programmatic mapping: 32,580 MSM 167,940 FSW, and 16,063 PWID. (NASCOP, KPSE phase I report, April 2019) A respondent-driven sampling (RDS) approach is being utilized in the ongoing Phase II size estimate. Since the estimates were based on the existing program reach, PEPFAR Kenya inferred 1% of all men aged 15-64 years are likely to identify as MSM. This increased the PEPFAR Kenya MSM targets to 80,064 in the 24 priority sub-national units (PSNU) where the program is intended to be implemented.

In COP20, there was disagreement between GOK and CSOs on the use of biometrics for which PEPFAR Kenya allocated funds. In COP21, there is need to continue with discussions to achieve consensus between the KP CSOs and the Ministry of Health, USG agencies, and other stakeholders on integrated biological and behavioral surveys (IBBS) or other alternatives to provide current epidemiological data to improve KP programing for epidemic control. This issue will therefore continue to be reviewed in COP21 and COP22.

The PEPFAR-supported KP program provides a comprehensive package of biomedical and behavioral services for prevention, diagnosis, and treatment of HIV, sexually transmitted infection (STI), and viral hepatitis. Despite availability of services, uptake remains suboptimal, largely because of stigmatization and criminalization of KP behavior. ART coverage through KP-friendly services is estimated at about 50% in all three populations. To address these gaps, PEPFAR invests in the sensitization of health workers and relevant authorities, as well as KP community engagement approaches, including funding of KP-led organizations to deliver services directly to community members and regular CSO stakeholder engagement for program guidance. The KP program has been redesigned through ambitious targets and resource allocation with an intention of meeting the 95/95/95 goal by 2025.

In COP21, PEPFAR will continue working with the Ministry of Health to create an enabling environment for KPs to access health services through policy development. In addition, PEPFAR will continue building strong partnerships with the Key Population Consortium of Kenya and Kenyan TG organizations through structured periodic engagements to ensure the KP program is owned and managed by KPs. Achieving sustained epidemic control will be predicated on achieving optimal coverage of clinical and prevention

interventions as well as on strengthening the national sustainability profile and leveraging transformative health systems investments. PEPFAR will support the Key Population Consortium to engage, sensitize, and strengthen the capacity of county and national administrative instruments for KP-related health and human rights issues in an effort to address the legal and structural barriers impacting the sustainability of KP program achievements.

2.1.7 Pre-exposure prophylaxis (PrEP)

Kenya PrEP service provision continues to be on an upward trajectory since the program launch in 2017. Target achievements have steadily risen over the years resulting in the ambitious targets of 100,000 PrEP_New in COP20 compared to 39,843 (105%) against the PrEP_New target of 37,947 in COP19. Recognizing the reduction in funding, the ambitious COP20 targets, and the need for efficiency in service provision, the Kenya program will maintain a flat target of PrEP_New of 100,000 for COP21.

PEPFAR Kenya aims to scale up PrEP service provision by integrating it into existing services within facilities and community programs in order to increase both reach by clients and sustainability. While PrEP provision will be extended to all populations at substantial ongoing risk of HIV according to the national guidelines, focus and scale up will be among AGYW, PBFW, negative sero-discordant partners, KP, and other men at increased risk of HIV including negative partners of index clients.

Specific targets are distributed as follows to help in monitoring: a total of 267,044 AGYW aged 15-24 years will be targeted with PrEP information, education, and communication (IEC) while an estimated 28,671 AGYW (aged 18-24 years) will be newly initiated on PrEP. Additionally, 23,632 FSW, 23,384 men aged 18-64 years who are at increased risk of HIV acquisition, 9,956 MSM (independent of the other men at risk of HIV stated above), 8,457 PBFW, 5,282 sero-discordant couples, 311 TG, and 310 PWID will be initiated on PrEP.

In total, the PrEP_Curr target will be 140,000 based on program data results of continuation rates at 40%. New products and technologies have recently been approved: injectable cabotegravir, the dapivirine vaginal ring (DVR), and the event-driven PrEP for MSM. Taking advantage of the guidelines review underway in COP20, these products and technologies will be incorporated in the national PrEP guidelines. In COP21, key priorities will include: 1) intensified demand creation by IPs to make the PrEP service widely known, reduce myths, and highlight the new products and technologies as options for easy use; 2) dissemination of new guidelines including re-orientation, capacity building and mentorship for service providers; 3) monitoring of quality service provision promoting PrEP continuation; 4) use of innovative strategies like multi-month prescriptions and dispensing (MMD), social media, and champions for follow up and support, especially as the COVID-19 pandemic requires avoidance of non-essential facility visits and large crowds; and 5) capacity building for accurate data capture and reporting. In addition, PEPFAR Kenya will work closely and collaboratively with GOK and other stakeholders to

realize a national PrEP campaign to augment the above efforts and increase PrEP demand and uptake. PEPFAR Kenya will pursue these strategies while ensuring adherence to the national guidelines for both PrEP provision and COVID-19 prevention measures.

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	48,846,268	100	9,458,149		9,525,115		4,933,053		4,881,715		10,234,031		9,814,205		KNBS, 2019 Census Vol III extrapolated from Spectrum 2021 Estimates
HIV Prevalence (%)		4.26		0.44		0.44		1.99		1.21		7.77		4.13	Spectrum 2021 estimates (total for 15-49 years)
AIDS Deaths (per year)	21,180		1,663		1,698		1,009		1,045		6,326		9,437		Spectrum 2021 estimates
# PLHIV	1,484,344		37,123		37,432		93,788		57,073		810,461		448,467		Spectrum/Naomi 2021 estimates (Projected to Sep, 2021)
Incidence Rate (Yr)		0.09						0.20		0.07					Spectrum 2021 estimates
New Infections (Yr)	39,108														Spectrum 2021 estimates
Annual births	1,422,033														Spectrum 2021 estimates
% of Pregnant Women with at least one ANC visit		97.3						97.4				97.3			KENPHIA 2018 (% with 1+ ANC visit during last pregnancy up to 3 years prior to survey)
Pregnant women needing ARVs	55,186														Spectrum 2020 estimates
Orphans (maternal, paternal, double)	2,145,055														Spectrum 2020 estimates (0-17)
Notified TB cases (Yr)	71,206		2,728		2,781		4,995		7,100		16,788		36,814		National TB Program data, 2018
% of TB cases that are HIV infected		26		14		15		16		8		42		25	National TB Program data, 2018
% of Males Circumcised		91.7								90.4				92.7	2018 KENPHIA, overall is for 15-64,
Estimated Population Size of MSM*	84,277														2018 KP size estimate
MSM HIV Prevalence		18													2018 KP size estimate
Estimated Population Size of FSW	167,940														2018 KP size estimate
FSW HIV Prevalence		29													2018 KP size estimate
Estimated Population Size of PWID	16,063														2018 KP size estimates
PWID HIV Prevalence		18													2018 KP size estimate
1.Fisherfolk **2.**Prisoners **3.**Uniform-ed services **4.**Military **5.**AGYW aged 15-19 **6.**AGYW aged 20-24	**1.** 123,065 **2.** 85,273-200,000 **3.** 108,000 **4.** 30,000 **5.** 2,498,353 **6.** 2,234,644														Data presented are for targeting purposes and may not reflect actual size. Sources various including: Fisherfolk: FELTP AA 2011; AGYW: KNBS 2019 Census; Others: NASCOP KPSE Consensus Report
Estimated Priority Populations Prevalence: Fisherfolk		33.8													Fisherfolk: IBBS 2018 among island fisherfolk,

If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources

Table 2.1.2 95-95-95 cascade: HIV Diagnosis, Treatment and Viral Suppression

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)***	**Viral Suppression (%) ** **	**Tested for HIV (#)*****	**Diagnosed HIV Positive (#)*****	**Initiated on ART (#)**
Total population	50,435,350	4.26	1,484,348	1,403,091	1,196,438	81	94	5,431,282	141,551	122,084
Population <15 years	19,390,251	0.44 (both Male & Female)	74,599	64,888	68,607	92	85	299,328	4,752	5,472
Men 15-24 years	5,036,116	1.21	57,073	50,557	28,966	51	87	452,109	3,802	2,981
Men 25+ years	10,231,805	4.13	448,467	425,490	333,247	74	95	1,172,983	43,925	35,981
Women 15-24 years	5,087,450	1.99	93,787	77,846	64,421	69	89	1,356,999	20,020	17,366
Women 25+ years	10,689,728	7.77	810,422	784,310	701,193	87	95	2,149,703	69,050	60,284
MSM	84,277	18	15,176	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
FSW	167,940	29	41,606	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
PWID	1,721	18	310	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
Fisherfolk	n/a	n/a	n/a	n/a	n/a	77	84	n/a	n/a	*n/a*

*Estimated national ART coverage as of Dec, 2019.
** Program/survey VLS among patients on ART
***Tested for HIV excludes 1,199,466 women tested for HIV for PMTCT for which age disaggregation not available, HIV positive excludes 17,166 women diagnosed through PTCT for which age disaggregation not available through DHIS.
Sources: Population – 2019 Census, PLHIV Estimates – spectrum estimates, On ART – DHIS, Jul-Dec 2019, viral suppression – national VL database Dec 2019, Testing and linkage DHIS KP population estimates by NASCOP

Figure 2.1.3 Updated National and PEPFAR Trends for Individuals Currently on Treatment
Data Source: DATIM and DHIS2

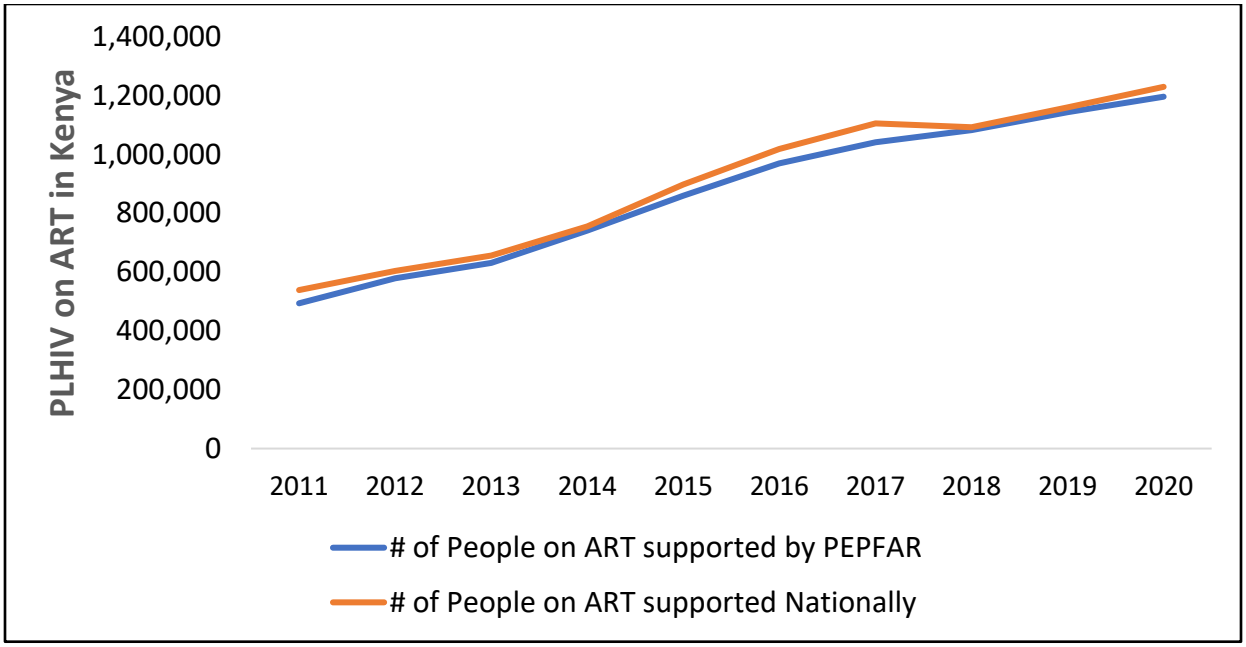


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV
Data Source: SPECTRUM FY21 Estimates

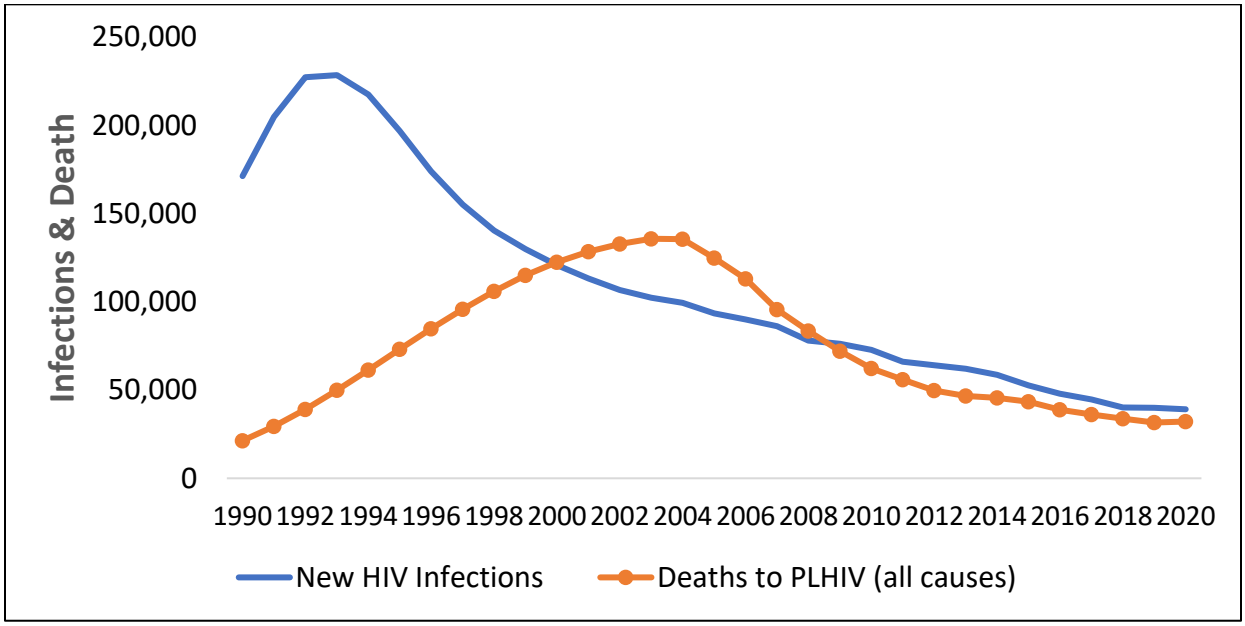


Figure 2.1.5 Progress Retaining Individuals on Lifelong ART in FY20

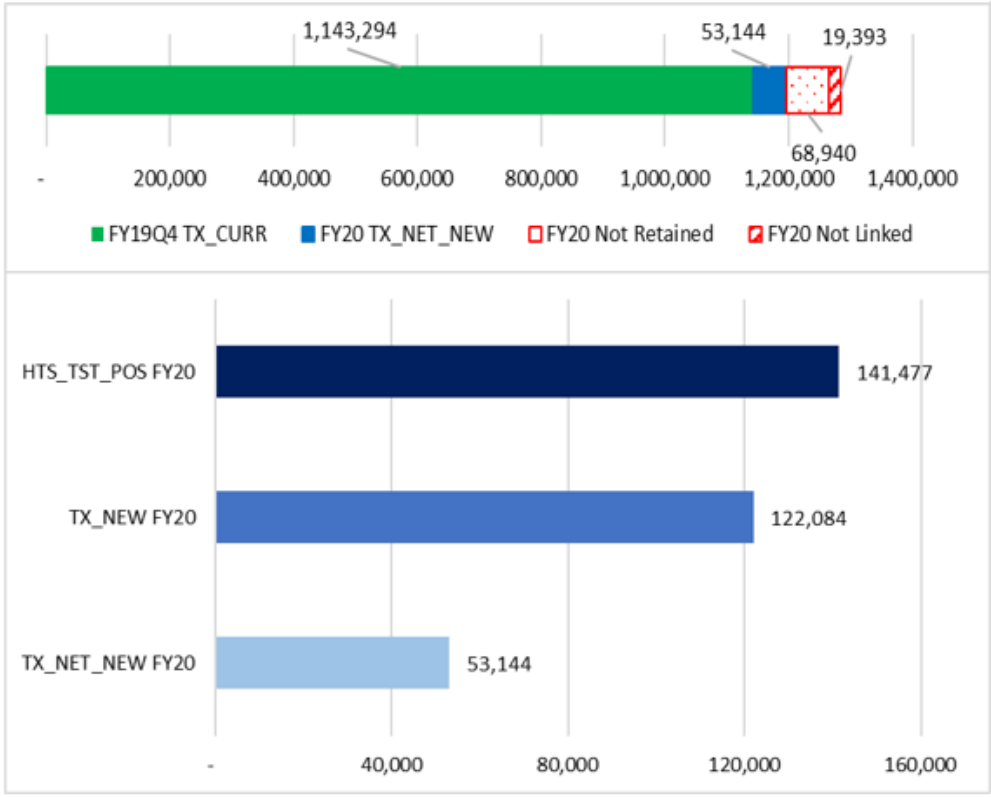


Figure 2.1.6 Proportion of Clients Lost from ART 2019 Q4 to 2020 Q4

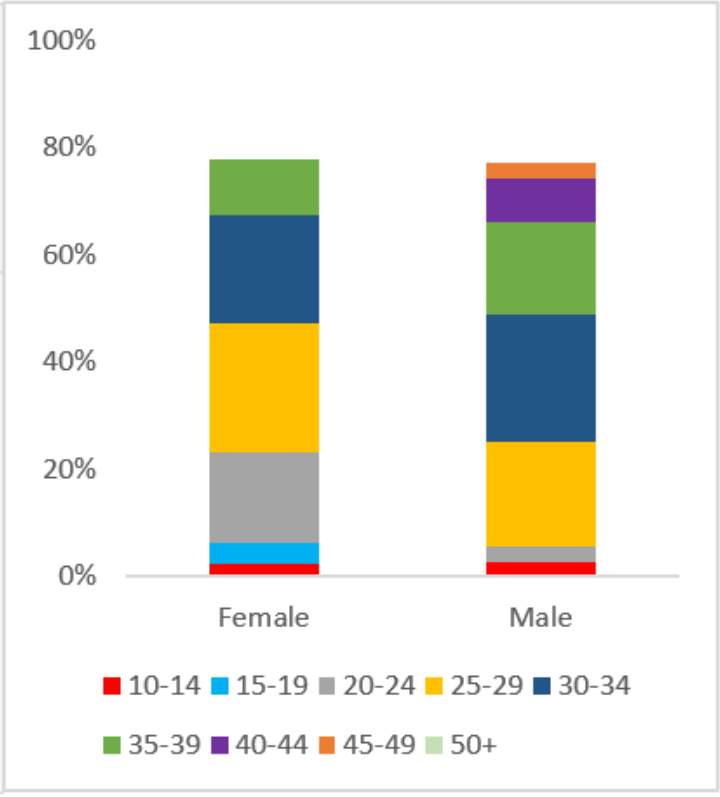


Figure 2.1.7 Epidemiologic Trends and Program Response in Kenya

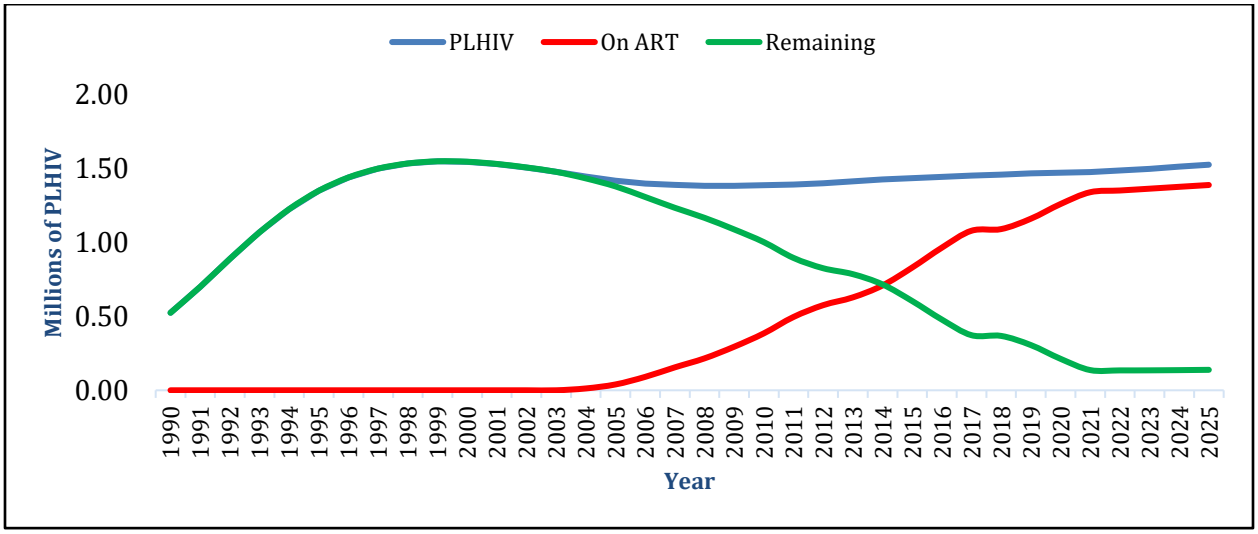
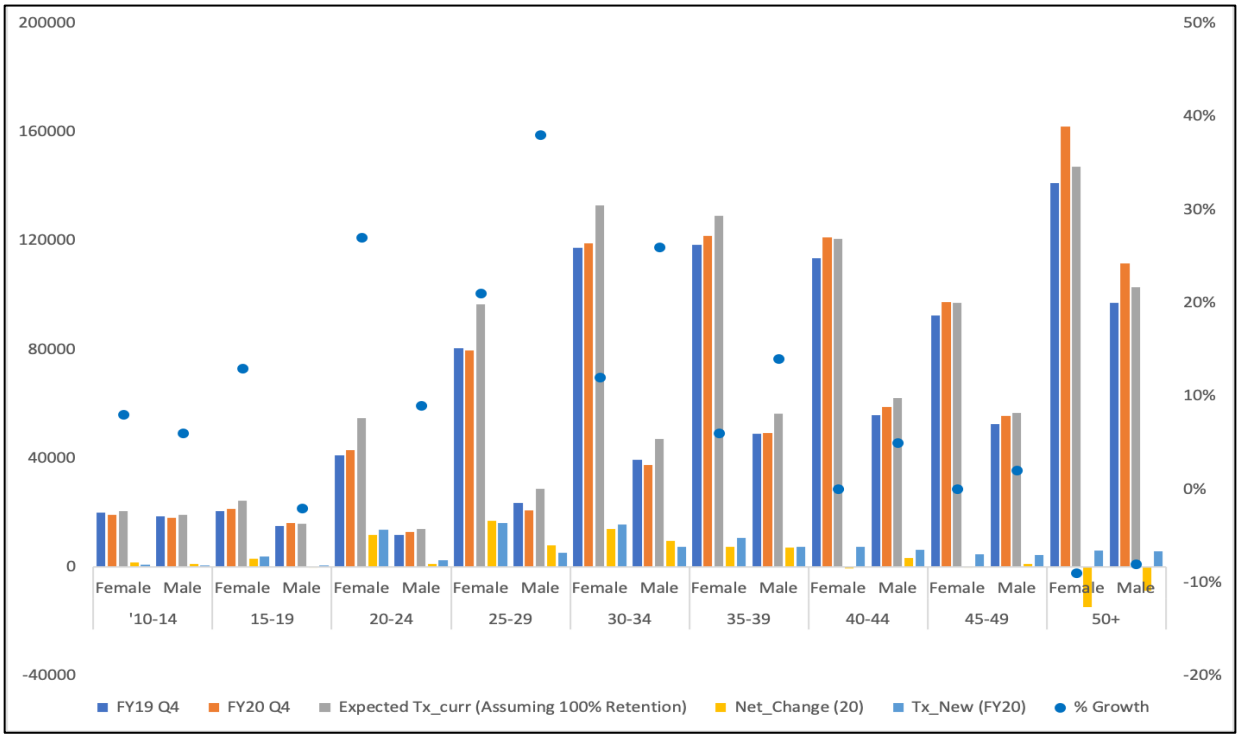


Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.8 Net Change in HIV Treatment by Sex and Age Bands, FY19 Q4 – FY20 Q4, all PSNU



2.2 New Activities and Areas of Focus for COP21

In COP21, PEPFAR Kenya will shift focus to age-, gender-, and population-based strategies to support continuity in treatment with a keen eye on the populations and regions that have registered high rates of interruption of treatment and slow cohort growth. Males aged ≥25 years and females aged 15-24 years will be given a priority focus as these population have been shown to be highly mobile with high rates of treatment interruption. Geographical focus will include counties and sub-counties, as well any other smaller but significant regional pockets with slow cohort growth as guided by data. The program will also prioritize VL suppression through demand creation for VL testing and optimized use of VL results for patient management, as well as ensure full scale up of DTG use.

2.2.1 Strengthened Client Linkages for Continuity of Treatment

PEPFAR Kenya remains committed to implementing quality client-centred linkage strategies across supported sites to ensure continuity of treatment among recipients of care through strategies that best address social and cultural needs of clients across all age, sex, and population groups and provision of comprehensive return to care package for clients who are re-engaged back to treatment. Ensuring continuity of treatment of individuals on lifelong ART—along with bringing back to care those who have experienced interruption in treatment—will be key interventions for PEPFAR in COP21 (Figures 2.1.5, 2.1.6).

PEPFAR Kenya will work with communities, FBOs, and CSOs to trace those who have interrupted treatment, relink them, and ensure continuity of lifelong treatment, with a special focus on young females aged 15-24 years and males aged ≥25 years. A return to care package will be developed and tailored to address the individual needs of recipients of care. Training on empathy will be done for peers and retention officers to ensure that all clients are adequately supported. Program evaluations and studies done on drivers of treatment interruption reveal that provider attitudes, long waiting hours, and conflicting work, school, and clinic schedules are contributing factors. These drivers will be addressed by customer care and interpersonal skills training, expanded non-facility-based drug distribution points, and roll out of flexi-clinic hours to serve those clients who cannot reach drug distribution points during official working hours. In COP21, PEPFAR Kenya will support scale up of private sector engagement—including decentralized drug distribution (DDD) points—to offer clients options and support continuity of treatment. The scale up of the DDD in COP21 will largely be informed by the SFI work undertaken in COP20 on client and pharmacy preferences in three counties (Busia, Nairobi and Kajiado).

The majority of clients who interrupt treatment have been those who are newly initiated on ART. Thus, all clients testing positive will be physically escorted to the clinician's desk and handed over to initiate treatment. Pretreatment assessment will be done to determine who needs what type of support and each client will be linked to services appropriately. COP21 will strengthen treatment preparation sessions beyond the initial pre-ART session so as to walk with clients through their first year of ART. Case management will be provided for all new clients with an emphasis on those with special needs identified in the pretreatment assessment.

COP21 will support the engagement of youth mentors to act as case managers to their peers. There will be a well-defined support system structure where issues that fall beyond the ability of the case manager may be addressed by trained counselors, clinicians, medical consultants, and social workers. Periodic client satisfaction interviews will be done with the aim of addressing client-specific gaps in management and making the HIV treatment program attractive to clients. COP21 will also support the employment of both proactive and reactive measures to ensure minimal missed appointments and rapid re-engagement into treatment for those experiencing interruption. Use of technology with bulk SMS reminders and Ushauri automated appointment and default tracing systems will be sustained.

In COP21, PEPFAR Kenya will support implementation of a private sector engagement initiative which entails a DDD system to improve continuity of treatment and offer clients choices with respect to when and from where they collect drugs, with data informing scale up. PEPFAR Kenya will use lessons learnt from the USAID-funded Sustainable Financing Initiative (SFI) pilot to scale up DDD. The SFI pilot was done in three counties (Nairobi, Busia, and Kajiado) to determine the potential of private institutions as drug distribution sites and their ability to serve as pick-up points. The pilot project also tested consumer interests across a range of indicators to better understand how and where to quickly start scaling up DDD in COP21. The Ministry of Health will play a key role in ensuring effective supply chain management, data capture, and reporting both for drugs and services.

COP21 will also support implementation of continuous quality improvement (CQI) and root cause analysis, linked to appropriate response by partners. Prior research on people who had interruption of treatment has shown health care worker attitudes toward HIV clients and perceived maltreatment as stumbling blocks to continuity of treatment. These issues are being addressed through continuous health care worker training and monitoring on attitude change in collaboration with CSOs. Return-to-care packages have been developed and will be provided for clients previously disengaged from treatment who are returning. The aim is to ensure that the issues, fears, and concerns that led to treatment interruption are addressed as they restart their treatment. Case management will be done for all clients returning to care with appropriate case managers chosen to address individual clients' needs.

PEPFAR Kenya will also work to ensure there is adequate linkage between the facility and communities for both data capture and referrals. Linkage registers and facility referral tools will be used to track and facilitate follow-up alongside complementary support to develop monitoring and evaluation instruments including ART distribution forms, fast-track forms, and registers. PEPFAR will continue to support the targeted community defaulter tracing management and retention through the OVC program.

2.2.2 Differentiated Service Delivery Models for Continuity of Treatment

One of the proven strategies to retain patients is to expand differentiated care by frequency of service. PEPFAR Kenya has been implementing differentiated service delivery (DSD) models since 2017, which has reduced the transaction costs for patient travel to facilities, increased peer support and community involvement, reduced workload for health workers, and maintained and improved patient outcomes.

COP21 will strengthen DSD models that respond to the needs of clients, taking care of special subpopulations like older working men, school-going children, PBFW, TB/HIV co-infected patients, and young adults with flexible clinic operating hours. Clinic operating hours will be extended beyond the 8:00 a.m. to 5:00 p.m. time period to open early and close late to serve populations working or in school during official working hours. In addition, weekend clinics will be operated to serve those busy or out-of-location during weekdays.

The facility Fast Track model is the most popular model of choice by clients on differentiated care in Kenya. COP21 will support improving this model by minimizing time spent by clients, setting a target of 30 minutes in and out of the facility. In high volume facilities, drug dispensing booths will be established to ease the client flow and congestion experienced in these facilities during drug pick up days. Peer mentors will be mentored and deployed in these booths to dispense the drugs and ease the strain on pharmacists. Community ART groups will take HIV services closer to the clients ensuring their life goes on as uninterrupted as possible.

PEPFAR Kenya, in COP21, will work to scale up community models of ART delivery. Different community ART distribution models will be implemented to give clients many options to choose what suits them. PEPFAR Kenya will also scale up differentiated drug distribution For youth, distribution by their peers will be scaled up in all regions of the country. PEPFAR Kenya program is already doing multi-month prescriptions and dispensing (MMD). Discussions have been initiated with the Ministry of Health to have a policy allowing up to six months dispensing of ART and this is expected to be reflected in the 2021 ART guidelines due for release in mid-year. As part of patient-centered care, treatment literacy will continue to be offered to stable patients in differentiated models.

2.2.3 Promote Positive Health, Dignity and Prevention (PHDP) for Continuity of Treatment and U=U for Sustained Viral Suppression

In COP21, Kenya will intensify and scale up PHDP interventions and patient literacy to all PLHIV aged >15 years and their caregivers at HIV clinical settings and in the community to prevent onward transmission of HIV, as well as to maintain the health of patients. PHDP interventions will be delivered by health care providers, counselors, and peer educators. Services will include: 1) risk reduction and condom provision; 2) STI screening; 3) family planning (FP) counselling; 4) pregnancy intention and assessment screening to add to the family planning services; 5) adherence and continuity of treatment interventions; 6) knowledge of status, partner, and family testing; 7) disclosure counselling; and 8) psychosocial support groups for all PLHIV. Meaningful involvement of PLHIV (MIPA) to

enhance adherence and continuity of treatment will be scaled up including peer models such as mentor mothers, adolescent and adult peer mentors, PHDP and evidence-based medication adherence interventions such as Operational Triple Zero (OTZ) at both facility and community levels. Adolescents and young people (AYP) aged ≥15 years will receive both OTZ and PHDP interventions.

To facilitate and ensure sustained viral suppression among PLHIV on ART, Kenya will intensify strengthening, implementation, and scale up of U=U activities through the Ministry of Health and networks of communities of PLHIV. Activities will include: 1) working closely with the Ministry of Health, PLHIV, and other stakeholders on identification of U=U champions nationally; 2) capacity building of health care providers and U=U champions; 3) development of standardized U=U messages and IEC materials for both the general population and different sub-populations (e.g. AYP, PBFW, KP); and 4) sensitization on U=U of different stakeholders including PLHIV, health care providers, and PEPFAR IPs. These activities will ensure sustained viral suppression among PLHIV in Kenya. To strengthen PHPD, OTZ, and U=U, implementation of structured patient literacy interventions be provided to support groups at facility and community levels

2.2.4 Viral suppression

PEPFAR Kenya continues to report improved suppression with overall viral suppression at 95% as of FY21 Q1. Across age groups, clients aged >50 years have surpassed the target suppression of 95% at 97%, with adults aged ≥25 years having suppression of 96%. Challenges remain in suppressing children, adolescents, and young adults, with suppression of children aged 0-15 years and 15-19 years at 87%. There is also varying performance among counties: 2 counties have suppression of less than 85%, 3 counties have suppression of 86% to 90%, and 36 counties have suppression of over 90%. The 2 counties with suppression of less than 85% have similar characteristics: both are vast semi-arid counties inhabited by highly mobile pastoralist communities. For COP21, focus will be on improving suppression among children, adolescents, and young persons while sustaining the successful strategies used in adults to maintain suppression rates. COP21 will strengthen access to VL testing and improve VL suppression through demand creation for VL testing services and optimized use of VL results for patient management. The program will also optimize transition to pediatric DTG (pDTG) for infants and children aged >4 weeks or >3kgs as one of the principal strategies to improve VLS in children.

2.2.5 Scale Up of Dolutegravir

As of the end of FY20 Q1, more than 500,000 PLHIV were receiving dolutegravir (DTG) as per the 2018 ART guidelines and the July 2019 NASCOP circular that allowed for use of DTG in women of reproductive age. These guidelines are currently under revision and DTG use will be explicitly captured as part of the revision. In FY20/21, Kenya will continue to scale up use of DTG per the WHO guidelines in combination with other appropriate treatment molecules. Kenya is already using DTG for the pediatric population and nevirapine phase out is now complete.

2.2.6 Additional Areas of Focus for COP21

COP21 will continue to support nutrition assessment counseling and support (NACS) and therapeutic feeding for severe acute malnutrition (SAM), cryptococcal meningitis screening, and ART monitoring as per national 2018 guidelines. In addition, COP21 will prioritize: 1) TB/HIV service delivery integration; 2) TB prevention and treatment through optimized routine TB screening; 3) improved diagnosis using GeneXpert and TB-LAM for all eligible individuals; 4) use of newer, efficacious, and shorter regimens such as 3HP and 3RH for the majority of PLHIV; and 5) provision of client-centered TB care and TB preventive therapy (TPT) among all eligible PLHIV and their contacts, including provision of ancillary drugs such as pyridoxine at no cost. Both PEPFAR site monitoring data and Ministry of Health data indicates that the majority of PLHIV in Kenya have been initiated on TPT. PEPFAR Kenya in collaboration with Ministry of Health and GF will be focusing on mopping up PLHIV who have never had TPT and initiating all eligible newly diagnosed PLHIV on the new rifapentine-based regimens.

Deliberate efforts will be made to engage PLHIV and members of KP in the development or modification of TB and HIV prevention and treatment literacy materials as well in the delivery of routine health talks in health facilities. COP21 will support TB and HIV guidelines review to support new testing modalities for TB among children, including the use of stool specimens. COP21 will also support optimized linkages to TB/HIV care for confirmed cases and contribute to both pharmacovigilance and HRH strengthening.

Service integration is credited for the successful TB/HIV program in Kenya. While there remain opportunities for improvement, PEPFAR Kenya, Ministry of Health, and GF remain committed to providing integrated, comprehensive, high quality TB and HIV care including management of OIs. During the current implementation period (FY21), PEPFAR Kenya has procured 47,000 patient doses of INH and 86,000 doses of B6. In addition, 37,500 3-month patient doses of 3HP will be delivered in FY21 Q4 and will be available for use during COP21 implementation along with 13,000 patient doses that will be delivered in FY22. The combined PEPFAR procurement of 97,500 patient courses covers 80% of PLHIV TPT needs for a period of 12 months. PEPFAR appreciates the Ministry of Health for rapidly availing funds through UHC to procure TPT commodities, as well as CHAI for their commitment to make the country commodity secure in the current financial year.

2.3 Investment Profile

The GOK remains committed to ending AIDS by 2030, making strategic investments in health to maximize impact while increasing domestic resources to sustain the national HIV/AIDS response. The GOK's prioritization of affordable healthcare for all under the universal health care (UHC) agenda will advance progress to ensure equitable and affordable access to quality essential health services, particularly for the disadvantaged, vulnerable, and poor in Kenya, including people living with or affected by HIV.

The current health financing landscape indicates an improvement in government financing to the health sector. The proportion of total government budget allocation to health for

both national and county levels has started showing improvement at 11.5% in Kenya FY (KFY) 20/21 after decreasing significantly from 7.8% before devolution in KFY12/13. However, direct out-of-pocket spending still remains a large source of health financing (accounting for 26.1% of total health spending in KFY15/16), placing vulnerable households at greater risk of incurring catastrophic or impoverishing health expenditures (estimated at 4.9% in 2018 down from 6.2% in 2013) (KHHEUS,WB,2018).

Funding to the health sector remains limited. The large proportion of government revenue used to finance debts and wages, coupled with slow economic growth and demand from other competing sectors, limit the expansion of health resources. The clamor for higher wages by public sector employees resulting in ongoing nationwide health worker strikes has contributed to the ballooning public wage bill (52% of government revenues in KFY17/18), leaving few resources to be used for health or other services.

While public sector contributions to HIV/AIDS have increased from 18.8% in KFY12/13 to 22.1% in KFY15/16, donors remain the predominant source of HIV financing, contributing 62.3% of HIV expenditures in KFY15/16. In KFY20/21, PEPFAR Kenya represents 60% of annual total investments across all HIV program areas (Table 2.3.1) down from 76.8% in KFY18/19. Households via out-of-pocket spending (9%) and employers (6.5%) have been excluded in the computation in Table 2.3.1. Kenya's contribution as part of its GF counterpart financing requirement has increased from $22 million in KFY17/18 to approximately $60 million in KFY20/21, as shown by the approved budget estimates for the National Treasury and Ministry of Health. Nevertheless, donors continue to finance the majority of ARVs (75% in KFY19/20 down from 86.4% in KFY18/19) and about 67% of all HIV test kits in Kenya (Table 2.3.2).

On average, county governments increased the proportion of their total budgets allocated to health from 13.0% in KFY13/14 to about 28% in KFY19/20 reflecting the extent to which county governments prioritize health investments over other sectors (although there are variations between counties). Anticipated increases in salary increments resulting from the ongoing labor disputes are expected to significantly impact county allocations to health. However, current efforts to rationalize staff and clean up payroll will help contain the wage bill (currently 76.8% of county allocations in KFY19/20) thereby freeing up resources to finance drugs, medical supplies, and other critical health service delivery inputs.

Significantly greater domestic financing for health and HIV is needed to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Increased government budget alone is inadequate to offset uncertainties in donor support. Efforts to increase the fiscal space for health must be accompanied with measures to address inefficiencies in the use of available resources, including health insurance reforms and other measures that could ensure greater returns on investment. Innovative financing such as engaging with the private sector and incentivizing government-led investments in the health sector will continue to be explored to expand uptake of HIV services, decongest the public sector, and ensure long-term sustainability of the HIV response.

Costing and Health in Kenya

GOK is in the midst of developing its National and County AIDS Strategic Frameworks, as well as finalizing the next round of GF applications for 2021-2023. The country is also concluding its next fiscal budgeting process for KFY21/22. Sustainability under the current government UHC roll out will require payment levels for the current NHIF premiums to include HIV/AIDS in the benefit package. It will also require the reimbursement process to be streamlined, including reforming the health financing system to support UHC roll out for equitable access to affordable quality health care services. External resources are off-budget and not included in the HIV/AIDS planning process (e.g. PEPFAR, CHAI, Gates Foundation, the Elton John AIDS Foundation); thus, to help encourage sustainability, these should be incorporated into national and county planning processes. Strengthened coordination between national and county government and stakeholders, as well as between intra-county stakeholders, is also required. Key areas of investment for domestic resource mobilization also remain, including technical and financial support toward both transition and strengthening of leadership responsibilities, as well as increased national and county GOK resourcing and recognition of the community workforce so as to reduce the HRH donor dependency ratio at community level.

Policymakers and partners involved in funding and managing HIV programs have a need for current information on how costs, financing, utilization, and performance of different patterns of delivery vary and the factors that affect them. Their ability to stay well-informed about costs and performance is limited by how the epidemic has evolved and complicated by variations in the rapid transformation of service modalities, including differentiated care, availability of HIV-related services at the sub-national level, characteristics of the population of persons newly infected with HIV, and price changes. This swift pace of change means that existing, one-time cost data quickly become dated and are of limited use for decision-makers and management.

This highlights the need for cost analyses that reflect the significant changes to HIV care cascades in recent years and the need for a system that regularly collects data to produce information required for effective decision making on a routine basis. Simultaneously, the reduction of international assistance on health and competing demands for public funding have increased emphasis on transparency of expenditures, health spending efficiency, and performance measurement in HIV-related services.

To address these issues, the PEPFAR Kenya team in collaboration with the Ministry of Health, National Treasury, and Council of Governors is undertaking a process to implement an Activity-Based Costing and Management (ABC/M) system application in Kenya to obtain routine cost information on the provision of HIV and health services at facility, community, and above site levels and to use this information to effectively allocate resources, improve monitoring efforts, and increase efficiency. This type of data may be used by policymakers and partners to assist in making more evidence-based decisions for budgeting and resource allocation, and improving processes and resource use.

This activity requires a diligent process that will not only help confirm the true costs of programming and comprehensive health service delivery under UHC but also establish efficiency and cost barriers to the provision of services with fidelity. To this end, beginning in COP20, the PEPFAR Kenya Interagency Technical Team, the OGAC Headquarters Country and Accountability Team, and the USAID Headquarters Sustainability Team have been working in close collaboration with the Ministry of Health's leadership on the Planning and NACC Costing and KASF II Working Groups, and the National Treasury and Council of Governor's Health Team to develop a plan for a robust costing system. Through USAID, additional non-HIV funds from Gates Foundation to further support this process will ensure additional resources will be available for non-HIV and UHC costing aspects to be covered under this process. The goal is for Kenya to develop more financially sustainable and effective HIV and health care platforms.

Table 2.3.1 Annual Investment Profile by Program Area FY20/21

Program Area	Total Budget (US$)	PEPFAR	GF	GOK	Other
Care and Treatment	356,821,643	59%	14%	10%	18%
HIV Testing Services	26,154,136	88%	12%	0%	0%
Prevention	69,420,043	42%	23%	19%	16%
OVC	50,763,262	96%	4%	0%	0%
Above Site Programs	16,888,566	68%	32%	0%	0%
Program Management	35,742,700	29%	24%	35%	13%
TOTAL	**555,790,352**	**60%**	**15%**	**11%**	**14%**

Source: Ministry of Health Printed Estimates 2020/21; National Treasury Counterpart Estimates 2020/21; Kenya Global Fund – request for application 2021-2023Application; Kenya NHA 2015/16

Table 2.3.2 Annual Procurement Profile for Key Commodities FY 2019/20

Commodity Category	Total Expenditure ($)	PEPFAR (%)	GF (%)	GOK (%)	Other (%)
PSM	10,051,326	61%	39%	0%	0%
Consumables	1,246,579	0%	100%	0%	0%
Rapid Test Kits	11,134,793	44%	23%	32%	0%
Viral Load	18,532,918	89%	-	11%	0%
Laboratory Supplies	1,131,739	37%	63%	0%	0%
CD4	-	-	-	-	-
Health Equipment	-	-	-	-	-
Medicines	2,230,520	88%	12%	0%	0%
Condoms and lubricants	3,528,655	0%	100%	0%	0%
Antiretroviral Drugs	107,984,159	40%	35%	24%	0%
TOTAL	**155,840,689**	**47%**	**32%**	**21%**	**0%**

Source: Ministry of Health Printed Estimates 2019/2020; National Treasury Counterpart Estimates 2019/2020; Kenya Global Fund 2017 application
Note: Rapid test kit expenditure is historical data based on expenditure in FY19/20
Note: Household and employer contributions excluded.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration FY 2021 (US $)

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	16,000,000	4,382,723	5	40,859,336	Supporting quality services for maternal and child health
USAID TB	6,000,000	4,148,772	2	4,705,744	Improving TB diagnosis, care and treatment
USAID Malaria	33,500,000	3,195,000	4	5,228,932	Supporting malaria prevention and treatment is select high burden counties
USAID Family Planning	20,500,000	4,773,890	5	40,859,336	Supporting FP services in the country
Nutrition	4,000,000	1,745,317	4	33,650,629	Support nutrition interventions in the country
DOD-NIH	338,142	338,142	1	-	Supporting RV 393 study, a prospective, observational cohort study of 600 HIV uninfected adult men and women at risk of HIV infection in Kisumu County, Kenya
CDC (Global Health Security)	-	-	-	-	-
DOD HIV Research	279,181	279,181	2	-	Supporting AFRICOS HIV Cohort and Pediatric Viral Load Studies (Science) in South Rift Valley and Kisumu West IMs
DOD Lab Support	100,237	100,237	1	-	Supporting proficiency panels for CRC lab and sample archiving
Quarantine	434,143	-		-	Surveillance of migrant populations and refugee camps
CDC DTRA	-	-	2	-	Disease surveillance, diagnostic of priority syndromic illnesses. Incidence and economic impact of Brucella. Non-HIV- FELTP activities

Global Disease Detection and Emergency Response	47,986	47,986	1	-	Building capacity, monitoring and detecting threats, responding to international emergencies and reconstructing health systems
Global Health Security: Program Costs	8,388,957	2,388,957	1	-	Help develop health systems that prevent avoidable epidemics, early threat detection and rapid and effective response
Global Public Health Capacity Development	-	1,400,000	1	-	Global Health Protection research to KEMRI and Ministry of Health
Improving Program Effectiveness	-	650,000	1	-	HIV/AIDS clinical research
Malaria	100,000	100,000	1	-	Malaria research
Pandemic Influenza	4,498,412	1,438,500	1	-	Flu research
CDC OD	1,738,213	148,286		-	Management support
COVID-19 CARES Act Funding	1,790,000	1,790,000		- -	
COVID-19 Other Funding	8,245,000	8,245,000		-	
TOTAL	**106,272,129**	**34,912,572**	**32**	**-**	

2.4 National Sustainability Profile Update

Significantly greater domestic financing for health and HIV is needed to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Increased government budget alone is inadequate to offset uncertainties in donor support. The GOK remains committed to ending AIDS by 2030, making for strategic investments in health to maximize impact while increasing domestic resources to sustain the national HIV/AIDS response. Further, the GOK's plan for prioritization of affordable healthcare for all under the UHC agenda will advance progress to ensure equitable and affordable access to essential health services, particularly for the disadvantaged, vulnerable, and poor in Kenya, including PLHIV. This year, OGAC will be rolling out the next SID and RM process as part of the COP20 to implementation. Guidance on this will be shared with all stakeholders.

The 2019 Sustainability Index and Dashboard (SID) 4.0 and Responsibility Matrix (RM) were implemented by the Ministry of Health under the leadership of the National AIDS Control Council (NACC), NASCOP, the National Treasury and Ministry of Planning, and the Council of Governors in partnership with PEPFAR, UNAIDS, and GF. Additional participants and invitees included the Ministry of Devolution, United Nations Joint Team

on HIV/AIDS (UNJT), World Bank, and other multilateral/bilateral donors, in-country experts and academia, CSOs, private sector, and PEPFAR Kenya. The SID and RM's findings continues to play an important role in the planning of COP21 investments, principally through improving approaches to 'sustainable' programs with the triangulation of SID 2019 with MER data, 2018 APR, FAST and Table 6 outcomes. For the GOK, the SID and RM remains a source to inform transition to greater domestic resource mobilization.

SID results showed some progress in Kenya toward sustained epidemic control. Two elements scored dark green but stakeholders still noted the need for an in-depth review with respect to further investments required in those areas (quality management and market openness). Four elements were light green noting progress toward sustainability but still require catalytic investments mainly by the local host government (performance data, policies and governance, planning and coordination, and domestic resource mobilization). The remaining 9 elements were yellow (described below) and needed some degree of support. As with the previous SID 3.0, no elements scored red.

Civil Society: Mappings of HIV stakeholders and coordinating points have not been prioritized and Kenya National Bureau of Statistics (KNBS) has not been engaged for information on sources of coordination. There are not strong measures to prevent duplication and accountability by all stakeholders in HIV programming. Private sector healthcare providers are infrequently included in planning and monitoring activity tracking.

Commodity Security and Supply Chain: There has been minimal increase in the GOK allocation for procurement of HIV commodities over the last three years and minimal Ministry of Health financing for supply chain functions and operations other than staff salaries at national and county levels. No comprehensive supply chain assessment to determine status and inform priorities and investments has been conducted over the last three years. However, in the last year, the Ministry of Health with support from PEPFAR, launched the first ever Health Products and Technologies Supply Chain Strategy 2020-2025, the implementation of which will address key health commodity systems barriers.

Private Sector Engagement: Ministry of Health, together with development partners, are currently working on a private sector engagement framework that will guide PEPFARs private sector engagement. The framework will provide a national strategy to guide coordination and integration of existing public health structures with the private sector in order to improve overall quality of care and decongestion of the public facilities. The National Health Insurance Fund (NHIF) should include a comprehensive HIV package for private health facilities.

In COP21, PEPFAR Kenya will embrace a client-centered approach through scaling up DDD and working with private and public sectors to explore insurance cover for HIV care and subsidization of HIV drugs for patients receiving services at private facilities by choice.

Although the majority (about 95%) of PLHIV enrolled in HIV care and treatment receive services in the public sector or through FBOs, 2% of patients receive care from private sector providers while another 2% either receive care through donor-subsidized social franchises or self-fund through private insurance and out-of-pocket payments. Currently, the private sector cannot access free donated HIV drugs for their patients.

At the end of 2020 Q1, Kenya was providing HIV treatment to 1,137,111 patients of which close to 9,000 were receiving services from the private sector network. With a TX NET_NEW of only 59,194 clients through FY19 this translates to a net gain of approximately 4 for every 10 newly-identified clients, Kenya continues to struggle with continuity of treatment of PLHIV within the treatment program.

Reasons why patients do not keep their health appointments or drop out of care altogether range from distance to hospital, other pressing commitments, or lack of transport. The distance that stable patients have to travel to pick up medication can be reduced by making drugs available within their community for pick up. Drugs can be dispensed by local pharmacies, private or public facilities, or other designated safe and privately-owned pick-up points. PEPFAR Kenya, through USAID, is leveraging Sustainable Financing Initiative funds to lay the groundwork for scaling up client-centered care and DDD. SFI funding is currently being used in three counties (Nairobi, Busia and Kajiado counties) to determine the potential of private institutions as drug distribution sites and their ability to serve as pick-up points. This includes testing consumer interest across a range of indicators to better understand how and where to quickly start scaling up DDD in COP21.

Epidemiological and Health Data: The system for uniquely identifying patients is weak. Integration of service data with other administrative data is not adequate.

Laboratory: HIV rapid testing as well as complex lab testing—EID, VL and HIV drug resistance testing (DRT)—are mostly done by donor-supported staff. Although sufficient instruments are available, the supply chain and specimen transport system are mainly donor supported. HIV-related lab testing (HIV rapid testing, CD4, VL, GXP, CrAg, HIVDRT) financing is donor dependent.

Service Delivery: GOK provides minimal (1-9%) financing for KP services. KP services rely on substantial external support. There is limited continuous structural engagement with CSOs to inform service delivery and programing and minimal focus by both development partners and GOK in supporting fully-functional, community-based service delivery.

Human Resource for Health/Health Workforce: For the last three SIDs, the HRH score has remained relatively unchanged. Domestic funding for health workforce interventions has not increased. Improvements are needed in health workforce management and monitoring, especially with respect to performance quality, supervision, and minimization of absenteeism. The community workforce is not recognized or well-resourced. Health workforce data systems are incomplete and not optimally utilized.

Technical and Allocative Efficiency: In spite of an increase in resource allocation, optimal utilization remains a concern. Areas of inefficiency are still to be determined and mitigation measures have not been put in place. Further, the country has no system for gathering cost information on a routine and standardized basis to inform decisions on resource mobilization and allocation. Data capture to determine and reconcile allocations and expenditures are not routinely undertaken.

Financial/Expenditure Data: There is limited financing in the government for conducting sustained surveys and surveillance activity. Development of a multiyear strategy with partners is necessary and should include annual costed work plans with a clear road map leading to sustainability.

Noting the drastic drops in CSO and private sector engagement, the SID activity recommended that, to improve sustainability, NACC develop a strategy to improve the coordination and integration of the private sector with the existing public health structures in order to enhance overall quality of care and decongest the public health facilities. CSO coordination requires improvement to reach communities at the center of the HIV response. CSOs also need to be meaningfully engaged in accountability mechanisms beyond the Interagency Coordinating Committee (ICC) and GF Kenya Coordinating Mechanism (KCM).

Transitions: County and Local Indigenous Partnerships: As part of the expansion of partnership with counties to work on a strategic, joint, and coordinated HIV response, PEPFAR Kenya's Interagency Team will work with the Council of Governor's leadership (in particular, the Health and Finance Committee) to support county governments to strengthen systems for a sustainable HIV and health response in programmatic, technical, and fiscal spaces. These efforts will include additional coordination and collaboration with the U.S. Treasury and HRSA to provide technical assistance as part of a joint assessment leading toward a partnership agreement between PEPFAR, S/GAC, and counties, as well as detailed PEPFAR-specific implementing agency MOU.

In addition, PEPFAR implementing agencies have made progress toward the global requirement of having 70% of funding and implementation be directed to local indigenous organizations. A summary of progress on the roll out of these efforts under COP19, COP20, and COP21 plans for county and local indigenous partner transitions are provided by each PEPFAR implementing agency below:

<u>USAID</u>
In Kenya, a key aspect of the journey to self-reliance is partnering with counties to strengthen local ownership and sustainability of results. Strengthening local institutions, promoting systems change, and prioritizing long-term outcomes is key. USAID will implement government-to-government agreements with counties that have demonstrated

commitment to effective, inclusive, and accountable problem-solving and co-financing to achieve shared results.

In COP20, USAID Kenya is transitioning service delivery activities from international organizations to local partners through issuing 11 new awards. USAID is taking a phased approach when implementing government-to-government funding. In COP20, USAID Kenya service delivery partners (SDPs) in Kakamega and Nakuru counties will sign fixed amount agreements (FAAs) with county government, which will be designed to mirror fixed amount reimbursable agreements (FARAs) under government-to-government programming. USAID Kenya will implement a public financial management risk assessment framework (PFMRAF), programmatic risk assessments at the national and county level, and Public Financial Management (PFM) funds flow reforms. These assessments will position USAID Kenya well to undertake government-to-government negotiations with Nakuru, Kakamega, Busia, Kilifi, Turkana, and Mombasa in COP20, with anticipated awards in COP21 Q1.

In COP21, USAID will have new HSS activities that will focus on the current identified needs for both the PEPFAR program and Kenya as a country. The new activities will build on previous PEPFAR Kenya-supported interventions, as well as incorporate lessons learned. The broad outcomes of equity, access, and resource optimization will be the focus along with the various components of the health system, including health financing, health products and commodities, health workforce, governance, partnerships, private sector, and social protection.

CDC

The CDC Kenya program has a robust history of funding local partners. CDC is on track to move from 62% of its program funding allocated to local partners in COP19 to 70% in COP20. CDC Kenya has plans to increase its funding to local partners to above 70% in COP21 and has initiated procurement options for county government-to-government cooperative agreements in COP20. The government-to-government cooperative agreements will expand in COP21.

DOD

DOD's move toward partnering with counties and transitioning responsibility and funding within PEPFAR has so far focused on HRH transition of GOK-recognized cadres. This approach in COP19/20 has so far enabled transitions in 3 counties: Nandi (100%), Bomet (40%), and Kericho (~50%). .

For the Kenya Defense Forces, more than 95% of HIV-related health care providers are uniformed (up from 10% in 2004) and there has been an almost complete transition of lab commodities and opportunistic infection medications to KDF responsibility. In COP21, a new activity to support costing of HIV services will be undertaken, to facilitate transition considerations.

The next phase of transition at county level in COP21 will continue building county capacity for program leadership through the Commodities and Clinical Technical Working Groups (TWGs). Additionally, DOD will continue to support the transition to leadership by CHMTs and sub-CHMTs. Direct county funding has been initiated through a phased approach, beginning with IP-to-county funding, in order to demonstrate a workable framework and accountability system. During FY20, an MOU format was developed to facilitate engagement and set commitments toward transition. So far, Kericho and Nandi county MOUs have been duly signed. Narok and Bomet county engagements are ongoing and are expected to be executed by the end of FY 21.

DOD's program transition to indigenous partners is being carried out through three defined approaches:

1. Reviewing the categorization of its IP and assessing its classification as a Kenyan organization.
2. Concentrating on ensuring that 100% of local IPs are indigenous organizations (this is currently the case and will continue into COP21).
3. Prioritizing sub-awards to Ministry of Health facilities and community organizations as much as the IM scopes of work allow.

<u>Peace Corps</u>

The US Peace Corps return to Kenya will work with PEPFAR and USG agencies and their IPs in prevention and care and support activities, specifically among youth and AGYW. The Peace Corps recognizes that only 59% of Kenyan youth ages 15-24 years are knowledgeable about HIV prevention. Peace Corps will implement activities to increase awareness and promote behavior change among this age group. The program anticipates the arrival of 36 volunteers in October 2021, who will work within the public health and education sectors in Kisumu, Kakamega, and Siaya counties. They will co-facilitate and/or co-train youth sexual and reproductive health (YSRH) sessions focused on HIV prevention for youth aged 9-24 years at youth clubs and camps. Sessions will cover the following:

1. Information, education, and skills development, including life skills to: 1) reduce HIV risk and vulnerability; 2) correctly identify HIV prevention methods; 3) adopt and sustain positive behavior change
2. Linkages to relevant youth-friendly prevention and clinical HIV services
3. Referral to HIV testing services
4. Stigma and discrimination reduction
5. Basic financial literacy using financial capability evidence-based interventions (EBI)

The volunteers will also work with Kenyan counterparts to increase the self-efficacy of PLHIV, including OVC and their families, to improve their well-being and resilience.

All activities will respond to and be aligned with GOK and the Council of Governors' HIV intervention frameworks. These volunteers and their counterparts will be working in GOK health facilities, secondary schools, and CBOs and FBOs. The HIV specialist will ensure

that training and programming funded by PEPFAR will be appropriately designed and implemented according to O/GAC guidelines. Additionally, they will coordinate the collection of data and submission of sub-annual program reporting (SAPR) and annual program reporting (APR) and the Peace Corps Kenya submissions of various planning tools.

The Peace Corps anticipates a progressive increase in volunteer numbers and an eventual expansion of project footprint within the country, to support all PEPFAR counties in the mitigation of HIV in Kenya.

US Treasury

US Treasury will work with the PEPFAR Interagency Technical Teams on costing, sustainable financing, commodities, and human resources for health to assess and quantify the current legal and fiscal investments by USG, as well as by GOK (including Ministry of Health, National Treasury, and the counties) and other key donors. The outcome of this technical assistance will contribute to the areas of prioritization that will inform both the responsibility matrix and fiscal appropriations by the noted donors with the goal to move Kenya toward a fully-funded and locally-managed HIV program.

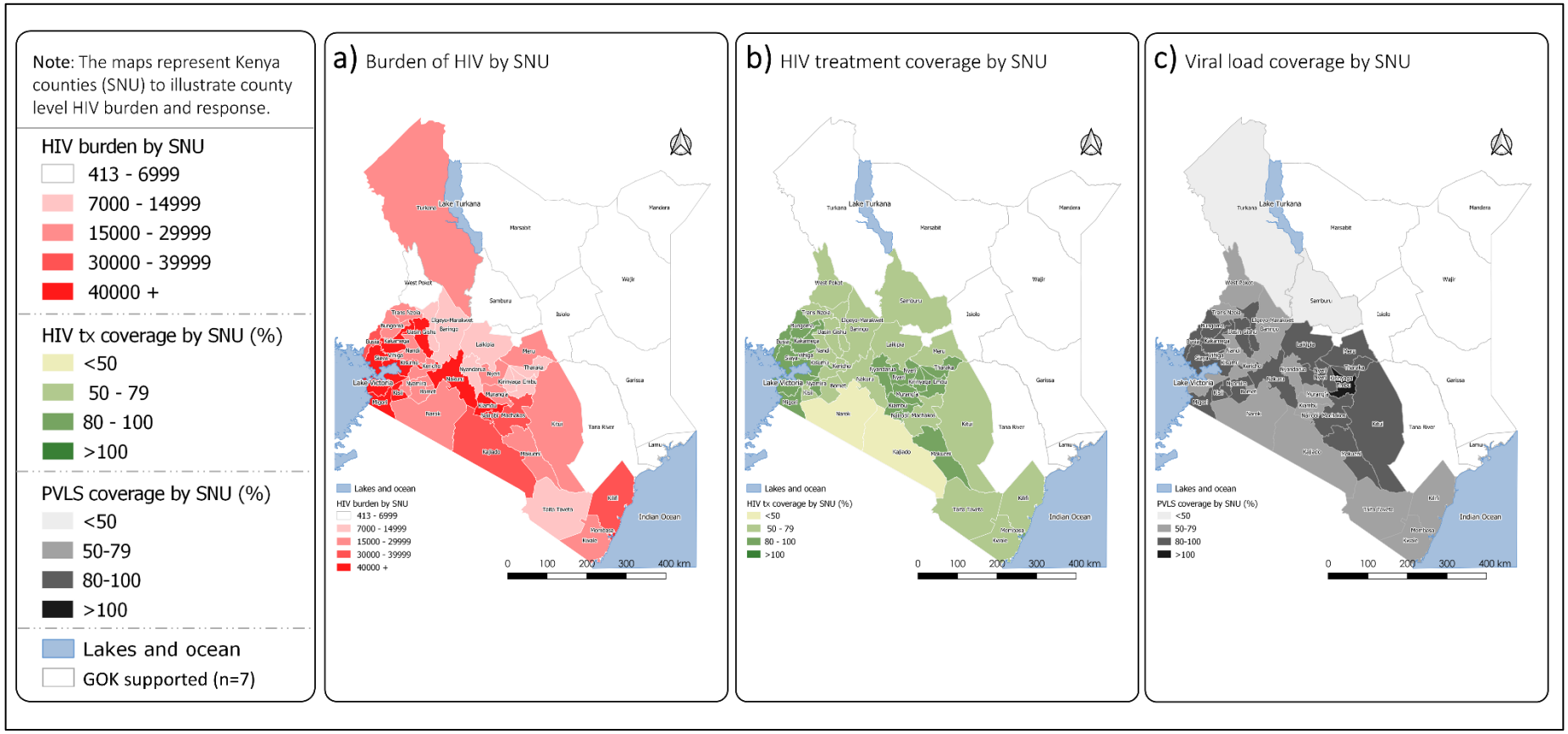
2.5 Alignment of PEPFAR Investments Geographically to Disease Burden

COP20 PEPFAR resource allocation was aligned to the county-specific needs for HIV epidemic control. Utilizing KENPHIA, Spectrum, and program data, resource needs were identified to close the county-level gaps in ART coverage and HIV incidence. In addition, resource needs to address population specific gaps such as HIV prevention among AGYW and KPS, as well as treatment gaps among children, adolescents, and young people were identified at county level. Allocation for COP21 continues this approach.

Overall, nineteen counties with high ART coverage (≥ 80%) but continued high HIV incidence—representing approximately 66% of national HIV burden—have been allocated resources to maintain the large ART cohort, adopt a public health approach to HIV case identification, and enhance HIV prevention. Ten counties with ART coverage of 70%-79% will be allocated resources to close the gap in identification through optimized testing while working to improve on continuity of treatment. Eleven counties with low ART coverage (<70%) contributing 14% of HIV burden but 88,375 of unmet need will be allocated resources for intensified HIV case finding and improved linkage and continuity of treatment on ART. Special consideration was made for counties with unique ART coverage and continuity of treatment challenges such as the nomadic populations in Turkana, Narok, and Kajiado Counties.

As expected with program-based budgeting, strategic objective costs varied across implementing mechanisms due to DSD models between government, non-government, and private facilities with both higher costs in hard-to-reach areas and patient density in high-burden counties.

Figure 2.5.1 HIV Burden by SNU, Total HIV Treatment Coverage by SNU, and Viral Load Coverage by SNU



Funding projections for meeting the COP20 targets were based on assessments of what partners actually spent in achieving similar targets in FY19 (Expenditure Analysis, 2019) and COP19 allocations. Reductions and increments, where applicable, were made based on proposed changes in approaches or projected efficiency savings. The funding landscape in COP21 has not changed much and aligns to the disease burden and county-specific needs for HIV epidemic control.

2.6 Stakeholder Engagement

The COP21 process began with the release of the draft guidelines for stakeholder feedback in December 2020. This was followed by a series of pre-launch meetings with an initial breakfast meeting between PEPFAR Kenya and GOK at national and county levels under the leadership of the Charge d'Affaires. Following the meeting, the PEPFAR Kenya team set up weekly bilateral meetings with GOK which included the Ministry of Health, the National Treasury, Directorate of Children Services and the Council of Governors. These meetings ran concurrently with the consolidation and drafting of the initial Kenya COP21 proposal. The second pre-launch meeting was a three-day consultation with the Council of Governors and county leadership from 45 counties, alongside national government representatives from the Ministry of Health, the National Treasury, the Directorate of Children Services, Global Fund and the UNJT.

The PEPFAR Kenya interagency team officially launched the COP21 process with all stakeholders (including CSOs, FBOs, and the private sector) at the end of January which included the participation of the S/GAC leadership and respective Agency Headquarters' Deputy Principles and Subject Matter Technical Leads. The launch was part of a three-day stakeholder retreat where progress on the current COP20 was shared, and strategic, programmatic, technical, data, policy gaps, and priorities were reviewed at national and county levels.

In early February, S/GAC issued a pause on all COP21 planning and engagement activities. However, prior to that, a series of global virtual meetings for stakeholders was also hosted by S/GAC. During the pause, the Kenya team engaged various stakeholders on current COP20 implementation issues including: 1) index client testing; 2) KP programming; 3) private sector engagement; 4) county technical support and transitions; 5) HIV investment and costing; 6) targets; and 7) commodities.

In mid-March, COP21 was relaunched. PEPFAR Kenya communicated and renewed its commitment to stakeholder engagements. Following a global virtual relaunch, PEPFAR Kenya together with the S/GAC Kenya chair, PPM, CAST, and ISMEs, hosted a series of Kenya-specific stakeholder listening sessions covering all HIV constituencies including the GOK, CSOs, and PEPFAR IPs. This was in addition to the two global stakeholder townhalls led by the S/GAC. The Kenya team also hosted a stakeholder meeting as part of the COVID-19 ARPA development process, which is to be submitted as part of COP21. The COVID-19 ARPA proposal, as well as the SDS, were then presented to all key stakeholders for feedback

feeding into the Kenya COP submission and approval meetings planned for May 7 and 13, respectively.

As part of the virtual in-country consultations, PEPFAR Kenya continues to hold joint meetings with the following GOK-led TWGs: 1) Clinical; 2) Prevention; 3) HIV and the Law; 4) Strategic and Health Information Systems; 5) Communications; 6) Key Populations; 7) eMTCT; 8) Commodities; and 9) Adolescent Girls and Young Women. Alongside the GOK-focused meetings, PEPFAR Kenya also continues to hold consultative meetings with: 1) CSOs as a consortium, as well as key meetings with AGYWs, FBOs, and KP communities, networks and leadership; 2) UNICEF and UNAIDs on PMTCT and FBO initiatives; 3) the private sector; and 4) the Council of Governors. The PEPFAR interagency team will also host meetings during the quarterly POART and conduct ad hoc meetings with CSOs, private sector, UNAIDS and UNJT, GF, and GOK in order to disseminate program results and information, as well as obtain input on programs with specific consideration for human rights, gender, people with disabilities, KP, and PLHIV. It is also critical that the COP21 process is closely linked to the finalization of the COVID-19 Global Fund Application Process and general Global Fund Year III Workplans and upcoming grant approval and rollout, as well as the 2020/2021 GOK budgeting processes.

All written feedback and PowerPoint presentations from key stakeholders, including the People's COP, have been reviewed and incorporated into the final COP21 SDS and plan. In addition to addressing the detailed program issues and priorities raised in the COP21 SDS as part of the sustained dialogue with all stakeholders, the PEPFAR interagency team will maintain stakeholder engagement throughout the COP20 and COP21 implementation process. The team continues to engage all key external stakeholders—national and county government entities, UNJT, GF, CSOs, private sector, and professional bodies—throughout the program cycle. With lessons learned from COP20, the PEPFAR interagency team will work with all stakeholders to review more timely, efficient, and accountable options for information sharing and meeting logistics given the present in-person meeting limitations due to the COVID-19 pandemic, as well as the need for cross-agency coordination of support to ensure external stakeholder representatives are included in meetings.

2.7 Community-Led Monitoring (CLM)

PEPFAR Kenya recognizes the critical role that CSOs play toward achieving epidemic control in Kenya. To this end, PEPFAR Kenya has supported CSOs in COP19 and COP20 to routinely collect patient- and provider-level data related to the quality of services provided at the site level in the three categories of counties (evolved, scale-up, and reboot counties). The data collected will be an additional data stream used in conjunction with PEPFAR MER, Site Improvement through Monitoring System (SIMS), and GOK monitoring and evaluation data to help improve HIV/AIDS service delivery. This initiative—the CSO Community Grant Initiative (GGI)—will have five major components:

1. <u>Support for a County Coordination Mechanism</u>

The County Coordination Mechanism will be compromised of all key stakeholders within the county, including GOK, CMHT, NASCOP, PEPFAR Kenya, GF, CSOs, FBOs, and the private sector. The coordination mechanism will meet quarterly to review all relevant data sources (DQAs, SQAs, MER, SIMS, CSO CGI, etc.) with the aim to identify things that are working well that can be scaled and issues/barriers that need to be addressed, as well as evaluate adequate utilization of resources (both human and financial) within the county.

2. Establishment of a Sustainable Data Collection Platform
   COP20 will support a web-based platform to aggregate and visualize patient and provider responses to questions using county government customer satisfaction surveys, SIMS, and the CSO Patient Satisfaction tool. This platform will provide users with real-time data on sites' quality of services derived from the responses.
3. Routine Collection of Patient and Provider Feedback
   Through locally-based CSOs or individuals, COP20 will help establish a schedule to collect and scale open-ended survey questions related to service delivery from individual patients and clinical staff at both public and private facilities within a given county. These questions and observations will be centered around programmatic themes as determined by the County Coordinating Mechanism and entered into an anonymized data platform that will be available internally for decision making, as well as publicly.
4. Capacity Building and Empowerment
   Grantees in the respective counties will benefit from the expertise and experience of other stakeholders to provide support and enhance the capacity of the awardees for an objective outcome.
5. Development and Implementation of a Data Quality Framework
   The framework will ensure data collected is in alignment with both the Kenya National Bureau of Statistics (KNBS) and United States Government. This will enable data collected to be recognized as quality data in accordance with local government standards and be interoperable with other data sources. An additional component will include capacity building of CSOs to adhere to quality guidelines in their collection of citizen-generated data.

Update on Community-led Monitoring in COP20

CLM is on track in COP20 for a late-May 2021 start date. The total amount expected to be awarded is $1.2m and PEPFAR Kenya is anticipating awarding a maximum of 15 awards.

Progress to date includes:

- Landscape analysis and review.
- Stakeholders consultations held.
- Concept note was developed and shared with OGAC and external stakeholders.
- Three NOFOs for each of the three components (e.g., coordination mechanism, routine data collection, and tools development) were published.
- Applications have been reviewed and a shortlist created.

- Risk assessments have been completed along with informational interviews with shortlisted applicants.

Next Steps:

- Late-April 2021: PEPFAR Kenya team will form a committee to review the shortlisted proposals and select awardees.
- Early-May 2021: Award process begins for selected COP20 grantees.
- Late-May 2021: Start of the implementation of the COP20 awards.

During the COP21 virtual planning meeting (April 20-21, 2021), the Kenya chair noted the concerns expressed by stakeholders. The chair indicated that he looked forward to seeing the start of COP20 CLM in May 2021. He further noted that a mid-point review of the COP20 CLM implementation would take place and, if at that time some of the issues raised by stakeholders were still possible, modifications will be made.

COP21 CLM Planned Strategy

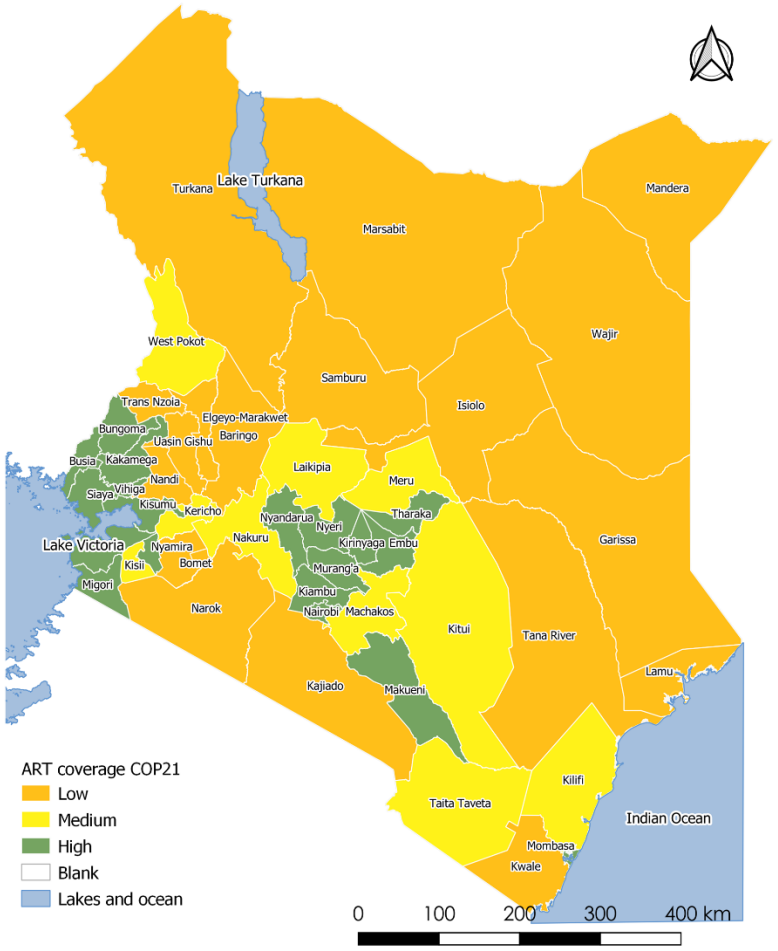
In COP21, will build upon the groundwork established during COP20. CSOs will be funded directly for CLM activities in COP21 through the PEPFAR Coordination Office's Small Grants Mechanisms (US $ 1.2 million). COP21 Notices of Funding Opportunities (NOFO) have been finalized and are ready for announcement in late 2021. Successful COP21 grantees will receive technical support from the CSO groups who led the effort in COP20. Some of this support will include:

- Training on CLM principles, methodology, and standards
- Support in engagement with PEPFAR teams for data triangulation and development of improvement plans for service providers
- Follow-up assessment of improvement plans and outcomes.

3.0 Geographic and Population Prioritization

HIV prevention interventions and rapid ART acceleration will be tailored to each county's epidemiologic profile, as well as to age and sex disaggregated ART coverage and unmet need. Using updated 2019 HIV spectrum estimates and survey and program data, the 40 counties receiving direct PEPFAR support will be categorized into 3 clusters to guide the case finding approach based on ART coverage: high coverage (≥80%), medium coverage (70-79%), and low coverage <70% (Figure 3.0). For each county, specific interventions for ART scale-up will be driven by granular data on burden, coverage, unmet need, yield, linkage, and net ART growth. County-level analysis will also include a review of HIV incidence data to guide a scale up plan for high quality, effective HIV prevention interventions including PrEP, DREAMS, VMMC, and KP programs.

Figure 3.0 COP21 County Categorization Based on Spectrum Estimates and Q1 2021 TX_ CURR Results



Criteria	High ART Coverage (19 counties)	Medium ART Coverage (10 counties)	Low ART Coverage (11 counties)
Survey Data	56% of all adult incident infections	21% of unmet need	45% of unmet need
Case Identification	High testing inefficiencies (at 35% of annual target)	Moderate testing inefficiencies (at 29% of annual target)	Higher testing inefficiencies (at 32% of annual target)
Linkage & Retention	Suboptimal proxy linkage & varying retention	Suboptimal proxy linkage & varying retention	Higher net loss of patients on treatment
VL Suppression	Low suppression among children	Low suppression among children	Low suppression among adults & children
PMTCT	Lower comparative MTCT rate	High MTCT rate	High MTCT rate

Data Source: Spectrum 2021 Estimates, PEPFAR Panorama

High Coverage

There are nineteen counties with a high ART coverage of ≥80% (Bungoma, Busia, Embu, Homabay, Kakamega, Kiambu, Kirinyaga, Kisumu, Makueni, Migori, Mombasa, Murang'a, Nairobi, Nyamira, Nyandarua, Nyeri , Siaya, Tharaka Nithi, Vihiga). Collectively, these counties contribute to 66% of national HIV burden and have unmet ART need of 117,210. The goal of COP21 in these counties will be to achieve and sustain the 95-95-95 epidemic control targets.

In these counties, a public health approach will be adopted for HIV case finding. Targeted testing strategies emphasizing diagnosing those who are still unaware of their status with high yields are required. This includes, but is not limited to, the offer of safe and ethical index testing at qualifying facilities to identify sexual and biological contacts of newly-identified PLHIV and those who are not virally suppressed. Other appropriate public health approach testing strategies such as social network testing and self-testing will also be implemented. In order to target interventions, full-scale implementation of recency testing will be used to define geographic "hot spots" and planned response to these hot spots, including case surveillance as appropriate.

At the health facility level, routine provider-initiated HIV testing and counseling (PITC) will be scaled down and interventions will shift instead toward diagnostic testing counseling to improve testing efficiency. A key focus will be the optimization of linkages and improved continuity of treatment of the large cohort of ART patients by implementing client-centered service delivery models, enhancing client tracking and return to care of those experiencing treatment interruption. Deliberate efforts will be made to strengthen adherence counseling and viral suppression.

In order to address the continuing high incident of HIV infections in these counties, ART scale up will be complemented by implementation of HIV prevention interventions. Specifically, age-appropriate evidence-based layered prevention interventions targeting AGYW aged 9-24 years will be implemented through the DREAMS initiative. A key area of focus will be geographic and population saturation among the most vulnerable AGYW in Nairobi, Kisumu, Homabay, Siaya, and Migori Counties. These counties will also be prioritized for VMMC, with a focus on males aged ≥15 years. Owing to the age 15-29 years MC saturation in Busia County, VMMC services are being transitioned to GOK. KP in these counties will be targeted with a combination HIV prevention services and support for an optimized clinical cascade among those who are HIV infected. OVC in these counties will also be provided with services, prioritizing the most vulnerable, with a goal of ensuring 90% of C/ALHIV receive OVC services.

Continuing on from COP20, these counties will engage in a self-reliance process to transition support of HIV services to the GOK and the counties. HIV clinical services will continue to be supported by one lead IP in the county, implementing an enhanced technical assistance model alongside continued right-sizing of HRH, with step-wise transition of mutually-agreed activities to county government.

PEPFAR will continue to focus direct support to large-volume, high-yielding sites. PEPFAR-supported DSD HRH levels will remain constant overall but may be reallocated based on where the need is greatest, in addition to the overall reassignment of appropriate level of effort (LOE) of HTS counselors to support continuity of treatment.

Medium Coverage
There are 10 counties (Kericho, Kilifi, Kisii, Kitui, Laikipia, Machakos, Meru, Nakuru, Taita Taveta, West Pokot) with medium ART coverage. These range from 70-79% and account for 19% HIV burden and have unmet ART need of 70,661. These counties will be supported to scale up safe and ethical index testing, targeted testing, and ART, in order to achieve >80% ART coverage.

Case identification will be done mainly through offering index testing at qualifying facilities to individuals newly diagnosed or with a recent non-suppressed VL test, efficient targeted facility testing, and self-testing for men and young people. Other appropriate public health approach testing methodologies will be implemented with the goal of offering testing to individuals unaware of their status and at high risk for HIV. In addition, enhanced support will be provided for adherence counseling, continuity of treatment, and viral suppression.

Similar to the high ART coverage counties, KPs will be targeted with combination HIV prevention services and support for an optimized clinical cascade among those who are HIV infected. The OVC program will prioritize the most vulnerable, with a goal of ensuring 90% of C/ALHIV receive OVC services.

HIV services in the medium ART coverage counties will continue to be supported by one lead IP in the county.. In order to achieve rapid ART scale up, partners working in these counties will be expected to meet their targets. Continuous partner monitoring will be done and IPs not meeting targets will be placed on a corrective action plan that will include HRH re-alignment. HRH rationalization and right-sizing will also be done to meet the workforce needs for these sites.

Low Coverage
There are 11 counties (Baringo, Bomet, Elgeyo Marakwet, Kajiado, Kwale, Nandi, Narok, Samburu, Trans-Nzoia, Turkana, Uasin Gishu) with low ART coverage of <70%. These counties contribute to 14% of HIV burden and unmet ART need of 88,375. They also account for 27% of adult incident HIV infections and 32% of new infections among children.

Rapid ART scale up will be supported in these counties to increase ART coverage, with case finding focused on intensified yet optimized facility testing including implementing risk screening tools in sites not yet using them. Additionally, qualifying facilities will offer index testing to individuals newly diagnosed as positive and individuals with a recent non-suppressed VP test result. Other appropriate public health approach testing methodologies

will be implemented with the goal of offering testing to individuals unaware of their status and at high risk for HIV. Given the challenges posed by the highly mobile nomadic populations in Kajiado, Narok, and Turkana counties, highly-targeted, population-based approaches will be implemented. The focus of treatment will be immediate linkage and optimized ART continuity of treatment and viral suppression, aligned with livelihood activities such as food distribution. Turkana county will benefit from GF support for HIV prevention among AGYW. VMMC will also be implemented in Turkana and Nandi counties based on low MC coverage and high HIV burden. KP in these counties will be prioritized for layered HIV prevention and an optimized clinical cascade for those who are HIV infected. Partner performance monitoring will be enhanced for rapid scale up of services. Additionally, a self-reliance sustainability process will be initiated, with the aim of commencing transition of HIV services to GOK and the counties.

Table 3.1 shows the current status of ART saturation and progress toward 95/95/95 across all SNUs as applicable.

Table 3.1 Current Status of ART Saturation FY20-FY22

Prioritization Area	Total PLHIV/% of all PLHIV for COP21	# Current on ART (FY20)	# of SNU COP20 (FY21)	# of SNU COP21 (FY22)
Attained	-	-	-	-
Scale-up Saturation	776,599 (52%)	685,978	18	18
Scale-up Aggressive	475,102 (32%)	376,875	12	12
Sustained	217,914 (15%)	130,516	10	10
Central Support	14,733 (1%)	-	7	7

4.0 Client-Centered Program Activities for Epidemic Control

4.1. Finding the Missing and Getting Them on Treatment

In COP21, PEPFAR Kenya will seek to close gaps in the 1st 95 for missing populations through county-specific tailored approaches. Case finding will shift toward a public health approach that will integrate disease surveillance and recency testing. At COP21's core, there will be increased engagement and collaboration with the Ministry of Health, both at national and sub-national unit (SNU) levels to enhance government-led case finding, monitoring, and response. Efficient and effective case identification strategies in COP21 will include implementation of safe and ethical index testing at scale with fidelity. Safety elements will be addressed and will involve intimate partner violence (IPV) screening, adverse event monitoring, and developing systems for community-led monitoring.

Targeted risk-based testing will be conducted at health facilities, with social networking strategies (SNS) for adolescents, young people, and KP. HIV self-testing will continue to be targeted to men and young people. Additionally, with policy and guidelines in place, recency testing will be rolled out to inform a targeted response for both case identification and HIV prevention services. Real time monitoring through electronic data collection for HTS services (eHTS) will be scaled up. To ensure a targeted epidemic response strategy, a public health approach to disease surveillance will be integrated into HIV case finding.

COP21 will use a number of strategies to address safety concerns surrounding index testing as outlined below.

Index Testing with Fidelity: Addressing Safety Concerns

Deliverables	PEPFAR Action Item
PEPFAR messaging to IPs will be devoid of a targeted % expectation from index testing. Index testing services will be offered to all eligible clients at facilities that meet the certification requirement.	• PEPFAR Kenya has communicated to all IPs that there is no longer a specific target for index testing. • Index testing will focus on a process that is fully compliant with safe and ethical index testing guidelines and that is fully respectful of the needs of the patient • IPs will continuously mentor staff that index testing is voluntary and that clients can decline the service for any or no reason. • IP work plans will not include targets for index testing.

PEPFAR IPs will collect and report routine data on the following index testing indicators: 1) # offered index testing 2) # who accepted index testing after counseling	• PEPFAR will work with IPs to ensure proper documentation in the index testing registers in order to enable collection of acceptance rates per facility and IP
PEPFAR IPs will monitor acceptance rates and offer technical assistance/QI where acceptance rates are higher than best practices suggest to ensure consent is meaningful.	• IPs will monitor safety concerns by facility and flag any site with safety concerns for immediate remedial action/steps. • PEPFAR Kenya will follow-up with IPs on any additional mentorship and supervision with regards to the message that index testing is voluntary and also ensure that the 5 Cs outlined in the HTS policy guideline are observed at all times.
PEPFAR Kenya will carry out investment in proactive monitoring for adverse events and quality.	• PEPFAR Kenya IPs will use the S/GAC Index Testing Minimum Program Components Tool to continually assess supported sites on safe and ethical index testing and identify program gaps for mentorship and training. • PEPFAR Kenya in collaboration with the Ministry of Health and other stakeholders will develop a multi-pronged, routine, continuous site monitoring plan covering: ▪ IPs role in site monitoring/QA including mentorship and supervision ▪ How to leverage/refine existing SIMS index testing monitoring questions to ensure they respond to safety monitoring aspects within index testing modalities/strategies ▪ County government and CHMTs' roles in quarterly monitoring of index testing programs ▪ How the community-led monitoring plan will be included in the quality monitoring plan/process for index testing programs. ▪ The schedule for routine monitoring by all multi sectoral stakeholders.
PEPFAR Kenya will support a certification process that moves quickly, in which any facility that does not meet minimum requirements will be temporarily halted from conducting index testing until these requirements are met.	• Participants during the certification process will include GOK, county governments, CSOs, Kenya Human Rights Watch, and other stakeholders • Certification goals will entail the following: ▪ An index testing services' certification tool for the facilities/sites adapted by GOK,

Note: Facilities that implement index testing are expected to meet certification criteria; however, it is noted that not every PEPFAR-supported facility will implement index testing.	counties, and stakeholders from the PEPFAR draft certification document ▪ Index testing certification for counselors, including a minimum of at least 1-year experience, aligned to GOK counselor certifications, and based on a stakeholder-adapted PEPFAR draft certification document
PEPFAR Kenya will share data on index testing cascades with GOK and other stakeholders as part of the monitoring system for all facilities moving forward.	● PEPFAR Kenya will report aggregated index testing services data starting with high volume facilities (e.g. those identifying >20 HIV positive per month) ● Monthly reporting for each facility includes: ▪ Aggregated # of clients aged >15 years offered index testing services ▪ Aggregated # of clients aged >15 years accepting index testing services ▪ Of those clients aged >15 years accepting index testing services, number of contacts listed by ages <15 years and >15 years. ● If a facility reports <20 clients offered index testing services in that month, a blank facility report with the note "low numbers reported" will be submitted ● PEPFAR will itself continue to assess sites with low volumes of clients offered index testing services (<20 clients per month). This will enable a phased approach by stakeholders by strategically focusing on facilities that report significant finding. ● Quarterly reporting for each facility will entail the following variables aggregated for clients aged >15 years across the entire index testing cascade ▪ # of clients offered index testing services ▪ # of clients who accepted index testing services ▪ Of those accepted, # of contacts elicited by age disaggregation of ages <15 years and >15 years ▪ Of the contacts elicited by the above age groups, # contacted, # known positive, # eligible for testing, # newly diagnosed HIV positive, # HIV negative, and # HIV positive linked to care.

Table 4.1.1 Case Finding Activities Based on Art Coverage Category: Evolve

ART Coverage	County	Subcategory	Strategic shift	Stopping	Scaling up
>80%	**Homabay** **Kisumu** **Siaya** **Migori** **Kakamega** **Busia** **Kiambu**	High PLHIV, High coverage	• Shift toward surveillance and a public health approach to case finding as counties achieve epidemic control • Continued strategic shift of HRH LOE toward support of high linkage and continuity of treatment services • Shift toward HTS offered by mainstream health care workers and laboratory staff while ensuring alignment to Ministry of Health guidance	Ongoing discontinuation of non-targeted OPD testing	**Index Testing and Recency:** • FY21: : Implementation of safe and ethical index testing that meets the recommended minimum standards and a focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for a public health approach to case finding • FY22: main case finding strategy - public health approach **PITC:** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI:** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years:** • Use of eligibility screening algorithm **PMTCT:** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC:** • Risk-based, symptom-based for aged >15 years **Target populations:** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing
	Makueni **Vihiga** **Nyamira**	Medium/Low PLHIV	• Close subpopulation coverage gaps and	Ongoing discontinuation of non-	**Index testing and Recency:** • FY21: Implementation of safe and ethical index testing that meet

	Embu **Tharaka-Nithi** **Murang'a** **Nyeri** **Bungoma** **Nyandarua** **Kirinyaga**		shift toward surveillance and public health approach to case finding as these counties achieve epidemic control • Continued strategic shift of HRH LOE toward support of high linkage and continuity of treatment services • Shift toward HTS offered by mainstream health care workers and laboratory staff while ensuring alignment to Ministry of Health guidance..	targeted OPD testing	the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding • FY22: main case finding strategy - public health approach. **PITC:** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI:** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years:** • Use of eligibility screening algorithm **PMTCT:** • Case finding for PFBW will be enhanced through maternal retesting as per national guidelines. **VMMC:** • Risk-based, symptom-based for aged >15 years **Target populations:** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing

	Nairobi	Urban county with large mobile population	• Focus on subpopulation coverage gaps and sub-SNU hotspots • Shift toward surveillance and public health approach to case finding as Nairobi achieves epidemic control • Continued strategic shift of HRH LOE toward support of high linkage and continuity of treatment services • Continued private sector engagement for case identification and referral to treatment	Ongoing discontinuation of non-targeted OPD testing	**Index testing** and Recency • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding • FY22: main case finding strategy - public health approach. **PITC** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years:** • Use of eligibility screening algorithm **PMTCT:** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines **VMMC**: • Risk-based, symptom-based for aged >15 years **Target populations:** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing, safe and ethical index case testing

	Mombasa	Urban area	• Focus on subpopulation coverage gaps and sub-SNU hot spots • Shift toward surveillance and public health approach to case finding as these counties achieve epidemic control • Continued strategic shift of HRH LoE toward support of high linkage and retention services • Continued private sector engagement for case identification and referral to treatment	Ongoing discontinuation of non-targeted OPD testing	**Index Testing and Recency** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding • FY22: main case finding strategy - public health approach. **PITC** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI** • Testing for HEI will be aligned to the national PMTCT guidelines **Pediatrics>2 years** • Use of eligibility screening algorithm **PMTCT** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines **VMMC** • Risk-based, symptom-based for aged >15 years **Target populations** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing
Note: All measures to ensure implementation of index testing with fidelity and safety considerations as guided in Table 4.1.2. above will be observed in all PEPFAR- supported facilities. PEPFAR agencies in collaboration with stakeholders will monitor and provide oversight toward ensuring safety measures within index testing programs are inculcated.					

Table 4.1.2 Case Finding Activities Based on Art Coverage Category: Scale

ART Coverage	County	Subcategory	Strategic shift	Stopping	Scaling up
70-79% (Scale)	**Kisii Nakuru**	HIV PLHIV, High coverage	• Continued strategic acceleration of case identification toward optimal ART coverage • Continued strategic shift of HRH LOE toward support of high linkage retention services	Continued discontinuation of non-targeted OPD testing	**Index testing and Recency:** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding **PITC**: • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-Testing:** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI:** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years:** • Use of eligibility screening algorithm **PMTCT:** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC:** • Risk-based, symptom-based for age >15 years **Target populations:** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing

	Kitui **Kericho** **Kilifi** **Meru** **Machakos** **Laikipia** **Taita Taveta** **West Pokot**	Medium PLHIV, Medium coverage	• Continued implementation of testing efficiency strategies that will ensure increased identification with minimal testing toward optimal ART coverage • Continued strategic shift of HRH LoE toward support of high linkage and retention services	Ongoing discontinuation of non-targeted OPD testing	**Index testing and Recency:** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding **PITC:** • Malnutrition, TB, STI • OPD testing - risk-based and symptom-based, diagnostic counseling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI**: • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years:** • Use of eligibility screening algorithm **PMTCT**: • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC:** • Risk-based, symptom-based for age >15 years **Target populations:** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing
Note: All measures to ensure implementation of index testing with fidelity and safety considerations as guided in table 4.1.2. above will be observed in all PEPFAR supported facilities. PEPFAR agencies in collaboration with stakeholders will monitor and provide oversight toward ensuring inculcation of safety measures within index testing programs.					

Table 4.1.3 Case Finding Activities Based on Art Coverage Category: Reboot

ART Coverage	County	Subcategory	Strategic shift	Stopping	Scaling up
<70%	**Uasin Gishu**	High PLHIV, high coverage	• Continuous reevaluation of ongoing testing strategies to align to aggressively and strategically accelerate case finding to scale up ART coverage. • Continued and strategic review of HRH requirements and appropriate size for effective case identification .		**Index Testing and Recency** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding **PITC** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years** • Use of eligibility screening algorithm **PMTCT** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC** Risk-based, symptom-based for aged >15 years **Target populations** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing

	Kajiado **Trans-Nzoia** **Narok** **Nandi** **Kwale** **Bomet**	Medium PLHIV	• Continuous reevaluation of ongoing testing strategies to align to aggressively and strategically accelerate case finding to scale up ART coverage. • Continued and strategic review of HRH requirements and appropriate size for effective case identification .		**Index Testing and Recency** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding **PITC** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years** • Use of eligibility screening algorithm **PMTCT** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC** Risk-based, symptom-based for aged >15 years **Target populations** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt out HIV self-testing and safe and ethical index case testing

	Baringo Elgeyo-Marakwet Samburu	Low PLHIV	• Continuous reevaluation of ongoing testing strategies to align to aggressively and strategically accelerate case finding to scale up ART coverage. • Continued and strategic review of HRH requirements and appropriate size for effective case identification .		**Index Testing and Recency** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding **PITC** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years** • Use of eligibility screening algorithm **PMTCT** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC** Risk-based, symptom-based for aged >15 years **Target populations** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt Out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt Out HIV self-testing and safe and ethical index case testing

	Turkana	Large county, difficult terrain, low coverage	• Continuous reevaluation of ongoing testing strategies to align to aggressively and strategically accelerate case finding to scale up ART coverage. • Continued and strategic review of HRH requirements and appropriate size for effective case identification .		**Index Testing and Recency** • FY21: Implementation of safe and ethical index testing that meet the recommended minimum standards and focus on mopping up testing of cumulative contacts/networks that are yet to be tested • FY21: establish case-based surveillance and recency for public health approach to case finding **PITC** • Malnutrition, TB, STI • OPD testing - symptom-based, diagnostic counselling and testing **HIV Self-testing** • Opt in self-testing for all that are eligible as per Ministry of Health guidelines **HEI** • Testing for HEI will be aligned to the national PMTCT guidelines. **Pediatrics>2 years** • Use of eligibility screening algorithm **PMTCT** • Case finding for PBFW will be enhanced through maternal retesting as per national guidelines. **VMMC** Risk-based, symptom-based for aged >15 years **Target populations** • KP and their clients – HIV self-testing, SNS, and safe and ethical index case testing • Adolescent and young people – Opt Out HIV self-testing, SNS, and safe and ethical index case testing • Men – Opt Out HIV self-testing and safe and ethical index case testing

Note: All measures to ensure implementation of index testing with fidelity and safety considerations as guided in table 4.1.2. above will be observed in all PEPFAR supported facilities. PEPFAR agencies in collaboration with stakeholders will monitor and provide oversight toward ensuring inculcation of safety measures within index testing programs.

Table 4.1.4 Finding Men: Strategies by County ART Coverage

High ART Coverage Counties	Medium ART Coverage Counties	Low ART Coverage Counties
Adult Men	**Adult Men**	**Adult Men**
● HIV active case surveillance using a public health approach. ● Index case testing with robust emphasis on implementation through a voluntary-based approaches and systems. ● Social network testing. ● Symptom based testing (DTC) including testing of patients with symptoms of STI and TB aiming to reduce testing volumes. ● HIV self-testing through utilization of community-based distribution channels and FBO initiatives to reach young men in communities. ● Recency testing and hot spot mapping to guide targeted case finding efforts. ● Scale up eHTS to improve data quality, reporting, utilization ● Immediate linkage of >95% of all new positives through interventions like linkage officers, tracking registers, locator forms, call back systems, and retrospective tracking of unlinked clients as well as peer escort systems ● Optimization (100%) referrals of clients with reactive self-test results for	● Appropriate messaging and demand creation for uptake of HTS among men. ● Index case testing with robust emphasis on implementation through voluntary-based approaches and systems. ● Social network testing. ● HIV self-testing through utilization of community-based distribution channels and FBO initiatives to reach young men in communities. ● Implementation of stringent integrated HTS eligibility/TB screening and age- and risk-driven testing for all eligible persons. ● Immediate linkage of >95% of all new positives though interventions like linkage officers, tracking registers, locator forms, call back systems, and retrospective tracking of unlinked clients as well as peer escort systems. ● Scale up eHTS to improve data utilization and reporting systems. ● Recency testing and hot spot mapping to guide targeted case finding efforts ● Optimization (100%) referrals of clients with reactive self-test results for	● Recency testing and hot spot mapping to guide targeted case finding efforts ● Appropriate messaging for demand creation for uptake of HIV testing services. ● Implementation of stringent integrated HTS eligibility/TB screening and age- and risk-driven testing to reduce testing volumes. ● Index case testing with robust emphasis on implementation through voluntary-based approaches and systems. ● Immediate linkage of >95% of all new positives through interventions like linkage officers, tracking registers, locator forms, call back systems, and retrospective tracking of unlinked clients as well as peer escort systems. ● Testing of all women with unknown status at 1st ANC visit and subsequent visits for those opting out at 1st ANC visit. ● HIV self-testing through utilization of community-based distribution channels and FBO initiatives to reach young men in communities.

confirmatory testing, linkage to treatment through male friendly, differentiated care that is client centered. ● Use of peer-to-peer support/escorted linkage to facilitate uptake of services /return to care and serve as coach or link facilitator ● Implementation of multi-disease screening booths and where feasible have express services for men	confirmatory testing, linkage to treatment through male friendly, differentiated care that is client-centered. ● Use of peer-to-peer support/escorted linkage to facilitate uptake of services /return to care and serve as coach or link facilitator ● Implementation of multi-disease screening booths and where feasible have express services for men	● Scale up eHTS to improve data utilization and reporting systems. ● Optimization (100%) referrals of clients with reactive self-test results for confirmatory testing, linkage to treatment through male friendly, differentiated care that is client-centered. ● Use of peer-to-peer support/escorted linkage to facilitate uptake of services /return to care and serve as coach or link facilitator ● Implementation of multi-disease screening booths and where feasible have express services for men

4.2 Ensuring Treatment Continuity and Viral Load Suppression

In COP21, PEPFAR Kenya's focus will strengthen and support continuity of treatment to optimize durable VL suppression. At policy level, COP21 will support commitment by stakeholders to have client-centered approaches to treatment. Ministry of Health 2021 ART Guidelines, as well as the 2021 Differentiated Service Delivery Operational Guidelines, do outline client-centered approaches, but 6-month MMD and specific populations (e.g. adolescents, PBFW) are not included in the policy. PEPFAR Kenya will collaborate with Ministry of Health to include 6-month MMD and DSD models contextualized to populations in the ongoing 2020 ART guideline review,

In terms of immediate linkage to treatment, there have been improvements in proxy linkage which is currently at 86%. However, gaps in linkage have been identified in males (82%) versus females (88%) and across age groups (e.g. males aged 20-24 years are at 78%, males aged 25-29 years are at 81%, and males aged 30-34 years are at 79%) (APR20 Program Data). COP21 will strengthen case management models through peers, especially for young men. It will also focus on partner management, especially in sites and facilities that have weaknesses in linkage.

PEPFAR Kenya will continue offering DTG-based regimens to all populations, especially women of childbearing age, for ART optimization. Of the current treatment cohort, 15% are not on a form of DSD, and less than 20% of those receiving DSD are on community-based models. PEPFAR Kenya seeks to improve uptake of community models to 35% in COP21. Additionally, there is low uptake of DSD among adolescent, paediatric, and other populations which COP21 will address through contextual population-specific models. This will include scaling up of community ART delivery models though community ART groups (CAG) and DDD models. COP21 will also work toward improving uptake of MMD. Currently, only 71% of recipients are receiving MMD for >3 months, with only 7% on 6-month dispensing. COP21 seeks to improve this to 80% of recipients on >3-month dispensing and 30% on 6-month dispensing.

PEPFAR Kenya will continue to support patient literacy activities. For recipients newly initiating optimized regimens, COP21 will support patient education on client-centered approaches for treatment including access to services in a convenient, hospitable, supportive, and accountable manner. COP21 will continue to prioritize specific gender- and age-differentiated interventions that are also convenient, hospitable, friendly, supportive, and accountable. To improve uptake of the community DSD model, PEPFAR Kenya will support demand creation through facility health education during health talks. Facilities will also use peers and health care workers to educate recipients of care on the available DSD models and their benefits. A robust client feedback mechanism will be incorporated to improve the quality of DSD service provision.

COP21 will continue to strengthen the therapeutic alliance between the patient, health system, and health provider. It will prioritize: 1) longer appointment scheduling for recipients of care, including factoring in the school calendar for adolescents as well as work

and travel schedules for young men; 2) appointment reminders through mobile applications such as the Ushauri platform; 3) redesigned patient flow such as Fast Track to reduce wait times; 4) specialized services for men, including extended hours and weekend schedules; and 5) defaulter tracking for those who have interrupted treatment, leveraging virtual platforms

PEPFAR Kenya will continue to track treatment cohort growth (Tx-NET NEW) across geography and populations and its relationship to TX-CURR and TX NEW. PEPFAR Kenya will continue to analyze interruption of treatment by geography, partner, and population through TX-ML and TX-RTT indicators.

Over the years, PEPFAR Kenya has meaningfully engaged communities during both planning and implementation of patient-centered care activities. Community engagement will continue to be strengthened in COP20 and COP21 through community-led monitoring (CLM). Community groups will receive funds to monitor the HIV response both at the clinic and community levels. Data collected will be triangulated with other data sources and be used to improve program performance. PEPFAR Kenya will conduct capacity building of CSOs to support CLM and strengthen ongoing activities that support meaningful engagement, including 1) engaging peers to counter stigma and support demand creation and retention in the various programs; 2) engaging patients and communities in program development and implementation at every level of the response; 3) establishing clear feedback loops for our services; and 3) in policy and advocacy.

As part of more meaningful involvement of PLHIV, PEPFAR Kenya supports peers who are adults or AYP in OTZ at facility and community level in the HIV response. Stable OTZ members are enrolled into either facility or community ART groups. These activities will also be strengthened using community-led monitoring. Use of the wider community health volunteer (CHV) model often raises questions of disclosure and confidentiality. PEPFAR Kenya is implementing caregiver training using MOH training material and also carrying out treatment literacy in OTZ to educate peers in order to ensure clients are empowered with the right information to take charge of their health

4.2.1 Improving Continuity of Treatment and Suppression among the Newly-Initiated and At Risk

Continuity of treatment plays a critical role in ensuring growth of the treatment cohort to optimize ART coverage with the endpoint of yielding good clinical and virological outcomes for PLHIVs. PEPFAR Kenya has critically looked at its data to understand the vulnerabilities leading to gaps in treatment continuity. In FY21 Q1 for instance, the major vulnerability was treatment interruption at 1.5% of the overall cohort (1.2% among the treatment experienced cohort) and more so among those newly initiating treatment < 3 months (11% of the total new cohort). Other smaller but important reasons included data quality related to transfer outs in the absence of a unique identifier, mortality, and a small proportion of recipients of care stopping treatment.

In COP21, the program will focus on strategies to mitigate treatment interruption among those newly initiating on treatment. The first strategy will be to assure durable linkage from case identification using case navigators. These individuals will not only link those newly identified to treatment but will ensure regular follow up even when they have started treatment and, as critically, in the first 28 days.

Second, COP21 will continue strengthening proactive measures to prevent treatment interruption. At individual level, PEPFAR Kenya will be providing tailored treatment literacy to recipients of care on the importance of adhering to medication and the need to inform the facility on movement in the event of migration. In addition, the program will continue to scale up m-health innovations that will help recipients of care get appointment reminders, as well as elicit feedback on their own care. COP21 will also ensure that these individuals are fully optimized with respect to the ART regimens they receive (DTG backbone regimens). Currently, based on data from the national VL dashboard, recipients of care on DTG-based regimens have the highest VL suppression at 97%. At facility level, COP21 will continue strengthening patient-centered models of treatment through a differentiated approach. WHO released service delivery recommendations in March 2021 allowing ART initiation in the community. COP21 will leverage these recommendations to strengthen community ART pickup and refills with the aim of preventing treatment interruption among those who would have benefitted from continuity of care this way. In addition, PEPFAR Kenya will strengthen clinic workflow design to allow for flexible schedules for those PLHIV who would opt for them, including early morning or weekend schedules, especially among males and young people whose treatment interruption rates are higher than for women and the general population.

Lastly, at a structural and policy level, PEPFAR Kenya will support the policy that allows for MMD up to 6 months and the easing of criteria about who is eligible for differentiated services, especially longer appointments. This is currently under review in the Ministry of Health 2021 ART Guidelines as well as the 2021 Differentiated Service Delivery Operational Guidelines which will be completed by mid-FY21 (under COP20)

The third strategy involves continuing to strengthen mechanisms to address treatment interruption. COP21 will support mechanisms to track, trace back, and return these individuals to care, as well as to document their outcomes. COP21 will focus on having adequate HRH champions to ensure that this strategy is implemented with fidelity. Finally, the program will invest in mechanisms to ensure proper documentation on treatment outcomes (e.g. transfers out, interruption of treatment, mortality, etc.). This will serve to ensure that PEPFAR Kenya can properly account for and quantify programmatic weaknesses. Mentorship and capacity building will be provided to health workers assigned to document these outcomes.

Specific to VL suppression—and in support of DTG-based treatment optimization—COP21 will strengthen standardization of adherence literacy approaches that are also tailored to specific patient needs. Through viremia clinics, the program will strengthen clinical

decision support systems to ensure an adequate VL utilization cascade and increase VL re-suppression rates.

4.2.2 Improving Continuity of Treatment and Suppression Among Children

COP21 will continue to support efforts to improve retention and viral suppression among children, especially children aged 0-3 years, and optimize treatment. GOK reviewed and revised ART optimization guidance for children, adolescents, and adults living with HIV. Guidance was provided for DTG-based ART for all eligible adults and children >20kg including women of reproductive age. In FY21, PEPFAR Kenya will work closely with the Ministry of Health to review and revise the national ART guidelines to include DTG-based ART for children aged >4 weeks or >3kgs and the removal of NVP and EFV regimens. The scale up of optimal ART regimens for all populations is expected to result in better viral suppression rates especially with the introduction of pediatric DTG (pDTG) in children aged <3 years who have lagged behind .

PEPFAR Kenya will work with the Ministry of Health towards policy review for MMD among children, with 3-month and 6-month MMD for CLHIV aged 5-10 years and family-centered clinic appointments aligned with caregiver schedules and children's school calendars. COP21 will prioritize multi-month prescribing and MMD as per national guidelines. Client-centered approaches will be adopted to ensure that stable patients have clinic appointments spaced out appropriately and that these are aligned with ARVs' dispensed and ART monitoring clinic visits. DSD models such as community ART groups, Fast Track, and Standard of Care will be expanded to ensure decongestion of facilities and increased efficiency in service delivery and continuity of treatment.

Further, the program will expand DSD for family-centered models of care, such as PAMA care for C/ALHIV and OTZ for adolescents. Family-centered approaches will be utilized to pair children aged 0-14 years and their caregivers, aligning with reviews and family-centered psychosocial support. Child-caregiver pairs who are both viraemic will be offered intensified case management and directly-observed therapy (DOT) where feasible, as well as linkage to OVC to address family, social, and emotional barriers at community and facility level in a bid to achieve re-suppression either before or after the switch to second line treatment. For children aged >10 years, enrollment to OTZ will be enhanced to foster self-driven health management among C/ALHIV in order to achieve higher suppression rates for this age category. Efforts will be geared towards providing friendly and responsive services to reach and surpass >90% VL testing coverage and suppression.

Although Kenya has made substantial improvement in viral suppression among children aged <15 years, there are some counties with VL suppression of less than 85%. COP21 will focus on these counties by adopting age- and geographic-specific models of care to enhance adherence to treatment and clinic appointments and improve county and overall national performance. In these counties, multi-pronged approaches including DSD, OTZ, community ART dispensing, and case management will be adopted.

COP21 will strengthen collaboration between OVC and clinical IPs to address the psychosocial and economic needs of children and high-risk adults who are caregivers. and to utilize case management approaches, including linkage with OVC services.

4.2.3 Improving Continuity of Treatment and Suppression among Adolescents and Young People

For adolescents and young people living with HIV, COP21 will scale up use of optimized DTG-containing regimens for all eligible clients. As with children, MMD and family-centered approaches for drug pick-ups will be implemented. Both healthcare workers and peer-led psychosocial groups will be utilized for treatment literacy and knowledge. Learners will be supported at school to adhere to medication and offered disclosure support.

COP21 will continue to support community approaches and a supportive social environment to increase adolescent and young adult adherence, foster HIV-prevention interventions, and reinforce individual behavior change efforts through peer groups and treatment buddies. Further, COP21 will use enhanced case management approaches such as Jua Mtoto Wako that leverage on synergy between community and clinical partners to develop individualized case plans to support adherence. OTZ champions will be used to promote appointment keeping and adherence, as well as work with schools to decrease stigma, discrimination, and violence against ALHIVs. PEPFAR sites will be supported to continue provision of psychosocial support and education-related to transition to adult HIV treatment using transition readiness assessments. Through community engagement forums, sites will meaningfully engage adolescents and young people and incorporate their feedback to further improve design and program implementation.

4.2.4 Improving Continuity of Treatment and Suppression Among Adults

In COP21, PEPFAR Kenya will continue to support ART optimization to ensure complete transition of all eligible PLHIV to DTG-based regimens as preferred first-line treatment including the newly-identified positives linked to treatment. In FY20, Kenya reported 844,995 patients (71% of all patients on treatment) on MMD. The program team will work closely with the Ministry of Health to adopt policy on 6-month MMD and fast track a drug refill model to ensure scale up of MMD to eligible PLHIV across all PEPFAR-supported sites.

The program will support provision of flexible or extended clinic hours for working clients and convenient community ART refill systems, including DDD in private community pharmacies. Male-friendly services - such as men-only clinic spaces and fast track waiting times for working men - will also be implemented. PEPFAR Kenya will enhance psychosocial support through scale-up of enrolment of newly-initiated PLHIVs to support groups.

PEPFAR Kenya will implement a patient tracking system. This will include tracking logs or missed appointment registers capturing information needed to track patients, methods,

and timing of attempting contact, and outcomes of each attempt. Sites will continue to integrate SIMS into their CQI activities and triangulate SIMS data with MER to identify gaps for decision-making and program improvement.

4.2.5 Improving Continuity of Treatment and Suppression within PMTCT

In FY 21, the PMTCT support will be restructured to focus on continuity of treatment on ART, VL testing coverage, and viral suppression. As always, PEPFAR Kenya continues to prioritize client-centered approaches to care. COP21 will support the development of client-centered high-risk categorization and management and improve ART cohort register documentation including reporting. Capacity strengthening for mentor mothers will be supported to provide structured peer-led support to improve adherence, continuity of treatment, and viral suppression among HIV positive pregnant and breastfeeding women. Individual case management will be promoted. ART optimization for PBFW will be scaled up as per national guidelines. In support of reduction of MTCT, individual case management of PBFW with high viral load test results shall be prioritized. To address low VL testing coverage reported in COP20, the program will conduct a data audit from the ART cohort register to confirm documentation and coverage followed by harmonization of the processes and measurements (VLC and VLS). The program will leverage onto OVC services to improve adherence, continuity of treatment, and EID outcomes. Cohort data reporting will be extended beyond site level (county, IP, and national level). PBFW and development of PMTCT-specific Undetectable=Untransmissible (U=U_ messaging in support of VL literacy.

4.3 Prevention, Specifically Detailing Programs for Priority Programming

4.3.1 DREAMS: HIV Prevention and Risk Avoidance for AGYW and OVC

The DREAMS program will continue to prioritize implementation within the high burden counties (Kisumu, Siaya, Homabay, Migori, Mombasa, Nairobi and Kiambu), targeting 321,241 unique AGYW and an additional 54,151 boys and girls who will receive a single school- or community-based evidence-informed violence and HIV prevention intervention. The unique AGYW target is a slight reduction from the COP20 target of 321,491. No geographic expansion beyond the seven DREAMS counties is envisioned. Instead, the program will improve service quality and expand coverage to above 100% for eligible recipients aged 10-24 years in the older DREAMS counties of Homabay, Siaya, Kisumu, and Migori. Coverage for Mombasa, Nairobi, and Kiambu will be adjusted to 90%, 85%, and 60% respectively based on the current estimates of AGYW population at risk.

4.3.1.1 DREAMS Progress and Package of Services

DREAMS Progress and Specific Plans for COP21

By APR2020 (COP19), PEPFAR Kenya had achieved 86% service package completion with 217,321 AGYW completing the primary package and required secondary interventions out of the 256,890 active AGYW in the program. This achievement was against a target of 252,000. COP20 had a target increase to 321,491 to cater for DREAMS expansion within the

high burden SNU's. In COP21, greater emphasis has been put on age-based saturation in the oldest DREAMS SNU's. The program will expand DREAMS implementation to increase program coverage at ward level and gain a geographic footprint in all the wards within older DREAMS counties that have the highest HIV burden in Kenya. The age group ratio has been shifted from 20%:35%:30%:15% for 9-14, 15-17, 18-19, and 20-24 year age categories respectively in COP20 to expanded coverage for AGYW aged 9-14 years at 42% of the unique AGYW operating unit (OU) targets to take care of an increase in AGYW phasing into the DREAMS program.

DREAMS intervention package completion has been best achieved after 13 months (> 87%). The program has therefore included an AGYW_PREV target of 60% for active AGYW within the financial year (<13 months) and higher completion rates for a >13 months period. The program will closely monitor and track intervention layering for service package completion at safe spaces by strengthening capacities for mentors to support service layering while maintaining contact with AGYW due to the prevailing COVID-19 situation to retain and increase the number of active AGYW.

The program will continue to build capacity of all IPs to use the already developed DREAMS dashboard to inform county-, ward-, and safe space-tracking of multiple intervention delivery. Partners will be expected to update intervention completion in real time to ensure optimal tracking of AGYW_PREV target gaps. Additionally, the DREAMS program will work closely with the DREAMS ambassadors and mentors to create demand for services among AGYW with poor layering. Consistent analysis of service package completion at ward and safe space level will inform adjustment to specific implementation strategies and reduce the risk of duplicative service provision. The program will work closely with Department of Children Services and the Ministry of Education to increase retention of AGYW in DREAMS and in school for school going AGYW.

To effectively track service integration with OVC, the DREAMS database will continue to include utilization of unique identifiers for OVC (CPIMS unique identifier) supported in the DREAMS program. Currently, the program has introduced a mediator layer using open HIM (http://openhim.org/) which will enable the DREAMS web application to be able to consume data from other systems. The initial implementation for this is with the new ODK service uptake form in FY21, where the data is sent to Open HIM, then Open HIM updates the DREAMS web App. This layer is envisioned to be used with any other system. The implementation can further be extended to enrollment data and opened to other systems including OVC. Moving into COP21, the program will transition the database to the government for sustainability with technical support by a local partner.

The DREAMS database helps track intervention layering by age categories among active AGYW and is based on an agreed OU level core package of services aligned to the Kenya layering table. The DREAMS database helps monitor overall partner progress towards achieving intervention package completion by age and SNU.

COP21 planning has utilized the 2019 Violence Against Children (VAC) survey report to generate post-violence care county-based targets. The program will continue to support the implementation of activities identified in the National Prevention and Response Plan on Violence against Children (2019-2023). Having adapted the WHO GBV QA protocol, the program will support capacity strengthening of service providers to ensure service integration in various service delivery points while scaling up clinical enquiry for GBV at all high-volume facilities. The program plans to digitize the QA assessment tool for ease of assessment and quick analysis of results to inform program improvement.

DREAMS will continue to benefit from services of the stand-alone GBV recovery center located in Kisumu, one of the DREAMS' SNUs. The program will continue to support the center's operation to ensure that quality and comprehensive services are provided to all referred AGYW within the DREAMS counties in Western Kenya along with other survivors of violence. AGYW sensitization on GBV, screening, and demand for services will be created to improve timely reporting and increased service uptake. The program also plans to operationalize the National Prevention and Response policy for GBV by building capacity of GBV stakeholders including the Department of Children's Services to enhance child protection in all sub-counties where PEPFAR implements HIV work.

Service Quality Improvement and Layering

In COP21, PEPFAR Kenya will focus on strengthening implementation of evidence informed interventions with fidelity to respond to the goal of reducing new HIV infections and preventing and responding to violence against AGYW. The DREAMS program will continue to address quality gaps with a focus on strengthening support supervision and assure quality implementation for sustained program outcomes. Specific focus will be on the following:

1. Strengthening age-appropriate combined socio-economic approaches (e.g. tracking the layering of services for out-of-school AGYW enrolled for comprehensive economic strengthening)
2. Monitoring layering of services and tracking primary and secondary packages of service completion using the DREAMS dashboard
3. Strengthening mentorship programs by: i) enhancing capacity of mentors; ii) streamlining the mentor-to-mentee ratio to 1:60 for improved mentorship; iii) providing empowering supportive supervision; and iv) ensuring that mentors are enumerated commensurate with their workload
4. Strengthening DREAMS/OVC integration and coordination between IPs and county stakeholders
5. Improving bi-directional referral for PMTCT and HTS_TST POS clients, who will be screened for DREAMS enrolment
6. Scaling up PrEP for AGYW within the DREAMS SNU's
7. Training mentors and intervention facilitators on LIVES and initiating psychosocial support for mental health improvement

The provision of multiple evidence-based services from the DREAMS core package of services (both primary and additional secondary or contextual) to each beneficiary is a core principle of DREAMS programming. In COP21, service provision will be centered around comprehensive service provision at safe spaces while scaling up promising strategies resulting from innovations due to COVID-19 situation. Active and completed referral for individual-based bio-medical services will be strengthened in situations where services may not be brought to the safe spaces due to COVID-19 protocol. Close monitoring of partners' performance will be prioritized to ensure that most of the services required are offered as applicable and in a timely manner.

Social Asset Building in DREAMS

PEPFAR will reach 321,241 AGYW within the seven DREAMS SNU's through an asset-based mentorship program. Whereas HIV testing and link to comprehensive post-violence care services are based on eligibility, HIV and GBV screening has now been prioritized as primary interventions to increase AGYW risk perception. Other biomedical interventions for eligible AGYW based on need will include condom education and provision, link to reproductive health services, and PrEP.

PEPFAR is currently promoting innovative ways in ensuring AGYW retention to the program due to COVID-19. Best practices through the use of social media (e.g. WhatsApp) platforms will be encouraged to help maintain contact with AGYW, while disseminating important messaging including demand creation for services such as PrEP for high risk AGYW.

Working closely with the ANC/PMTCT program and HTS sites, HIV negative AGYW will be screened for DREAMS enrollment where eligible. To enhance their safe space participation, the DREAMS program will accommodate their child-care needs through engagement of baby minders and/or structured safe space activities at health facilities around clinic days.

Based on program experience, consistent participation of older AGYW (aged 18-24 years) remains a challenge because of their competing needs. For example, some of them are already married. The frequency of safe space meetings will be reviewed to improve their service uptake, participation, and retention in the program.

Priorities for COP21 DREAMS implementation will involve exiting older AGYW who are fully layered, while systematically identifying and enrolling additional AGYW that are most vulnerable to HIV acquisition. COP21 will also improve the package of economic strengthening services to include: 1) market analysis; 2) gender- specific training; 3) post-start up support; 4) access to savings groups; and 5) coaching/mentorship.

Reaching Male Sexual Partners of AGYW through DREAMS

The program will continue to use the safe space platform to characterize male sexual partners of AGYW. DREAMS IPs will work with other PEPFAR programs to reach male

sexual partners with effective biomedical services such as HTS, condoms, VMMC, ART, and violence prevention. AGYW aged >18 years enrolled in DREAMS will be encouraged to discuss the referral services with their sexual partners and facilitate referral for services As appropriate.

PrEP Scale up in DREAMS

DREAMS program will continue to scale up PrEP implementation among eligible AGYW aged 18-24 years. The program will enhance HIV risk identification at recruitment and enrolment of AGYWs. General HIV prevention education that includes PrEP will be offered with deliberate and continuous screening and risk assessment done as the AGYW continue to receive other services.

Mentors' capacity and sensitivity will be enhanced to identify challenges that their mentees could be experiencing and identify and support those who could benefit from PrEP. DREAMS will ensure support for continuation through adaptations and use virtual platforms like social media and individual follow up while observing COVID-19 protocols. As in COP20 the program is working with Ministry of Health to incorporate new technologies into the PrEP guidelines, including DVR for women aged > 18 years. When DVR becomes available in the country, it will be included in PrEP awareness, education, and capacity building materials and be made available to young women as a choice among other comprehensive HIV prevention modalities.

In COP21 the program aims to initiate 12,663 AGYW on PrEP and monitor the quality of service provision and continuation. DREAMS program has prioritized screening for PrEP as part of PrEP education among the primary interventions for the older AGYW aged 18-24 years.

Combined Socio-Economic (CSE) Approaches and Education Subsidies

Achievement of comprehensive economic strengthening interventions has been low over the years (50% target achievement in FY20) and lately impacted by COVID-19 via frequent school, Technical Vocational Education and Training institutions (TVET), and college closures. The PEPFAR country team will continue to work with IPs to support market driven vocational training. Linkage with private sector, international agencies and national, and county governments will be encouraged to secure employment and entrepreneurship opportunities for DREAMS beneficiaries. The program will explore potential job opportunities and tailor vocational training to such opportunities. A total of 204,562 AGYW will be taken through financial capability training, out of which 34,293 AGYW will be screened for interest in business and will be trained on entrepreneurship. Readiness assessment and business plans will be reviewed for business start-up support and/or linkage to financial/loaning institutions and other government grants such as the youth fund.

Additionally, 7,361 of the AGYW aged 20-24 years will be supported through fee subsidies to join vocational institutions for market-driven courses. Fee subsidies will be prioritized,

however, to ensure retention, transport, and/or baby minders for AGYW with children in need of care. Efforts will be made to ensure that fee payment is cost shared for beneficiary commitment to course completion. Additional AGYW ambassadors will be identified and linked to employment as mentors, facilitators, or data clerks in the DREAMS program. The program will work closely with the DREAMS ambassadors to identify AGYW for specific economic strengthening interventions as appropriate.

The program will also work collaboratively through public-private partnerships to increase training, support, and linkage to job or business opportunities for older AGYW beyond PEPFAR targets. A further 46,402 AGYW aged 9-19 years in school will be supported through fee subsidies. Emphasis will be on supporting a majority of AGYW transitioning to secondary schools where risk of drop out is the highest.

DREAMS Collaboration with other Stakeholders

COP21 will be aligned to the GF investments to expand coverage for DREAMS. PEPFAR Kenya will work closely with NACC, DCS and the GF recipient partner to discuss existing structures and opportunities to facilitate geographic expansion and saturation. The program will actively participate in national and county adolescent and youth TWGs and related fora for continued collaboration and scale up of DREAMS. In COP21, the program will accelerate program saturation, while increasing ward coverage to reach most vulnerable and at risk AGYW within the current targeted counties. Expansion of DREAMS to cover additional high burden counties will be prioritized in the future as some of the current DREAMS counties move to a phased maintenance mode.

DREAMS Targeting Process for COP21

Of the 321,241 AGYW to be reached in COP21, the distribution of AGYW targets by SNU was arrived at based on the following:

1. Utilization of 2019 Census estimates, Spectrum estimates for 2020, KDHS 2014, KENPHIA data, and the 2019 VAC survey to calculate vulnerability parameters that included orphanhood, teenage pregnancy, school dropout, exposure to violence, multiple sexual partnerships, and non-use of condoms
2. Calculation of total at risk (aged 10-14), (aged 15-19) and (aged 20-24) factoring in estimates of the above vulnerability parameters
3. Three DREAMS counties appeared to have premature saturation (Siaya, Kisumu and Homabay) at 75% expected level in COP20. This led to resetting saturation at 100%
4. Calculation of estimated program coverage (FY21). The highest coverage was in Siaya (88%), Kisumu (93%), and Homabay (76%) counties, despite Kisumu and Homabay not having gained full geographic coverage
5. Utilization of at risk population of AGYW by age as the denominator to calculate FY22 and COP21 targets assigned at SNU level
6. Analysis of performance gaps to increase coverage using projected service package completion for FY22
7. Estimation of the expected number of AGYW to fully layer and complete the package of required interventions and total fully layered by FY22 Q4 to get the

projected coverage at Fy22 Q4. A phased approach to maintenance is therefore envisioned for AGYW aged 15-24 years by the end of FY22.

8. Created opportunity for aging in, leading to an increased target for AGYW aged 9-14-years of 135,377.

DREAMS program coverage varied across SNU's with the least covered being Nairobi and Kiambu at 85% and 61% respectively. Applying the urban approach to programing, expected coverage was increased substantially to expand implementation in informal settlement areas.

Below is the COP21 target distribution by age and county:

Table 4.3.1: FY21 DREAMS Targets by SNU and Age Group

Age Category	Nairobi	Kiambu	Mombasa	Siaya	Kisumu	Homabay	Migori	Total	Proportion Distribution
10-14	30894	14058	14430	10741	14829	22427	27998	135377	42%
15-19	34454	11728	11994	6003	3009	3910	9613	80710	25%
20-24	47293	16423	21425	3007	2643	1449	12915	105154	33%
							TOTAL	**321,241**	**100%**

Summary of Dreams:

1. Kenya will continue to implement DREAMS in 7 SNUS (Homabay, Siaya, Kisumu, Migori, Nairobi, Mombasa and Kiambu).
2. PEPFAR Kenya will reach 321,241 AGYW ages 10-24 years with comprehensive biomedical, behavioral, social protection, and structural interventions based on the Kenya DREAMS package of interventions.
3. Key priorities include increasing coverage in all wards in the high HIV burden counties of Siaya, Homabay, Kisumu and Migori, and layering of interventions to increase service package completion of up to 60% in <13 months to reach saturation.
4. PEPFAR Kenya will strengthen mentorship programs and engagement of AGYW across the entire program cycle.
5. Comprehensive economic interventions will be strengthened to include market driven vocational training, business startup, apprenticeship and employment based on AGYW preferences and strengths.
6. Support GOK to strengthen violence prevention and response including: i) sexual and GBV medical and forensic management ii) training health care workers to support a comprehensive clinical package of post-violence care and iii) working with the children's department to strengthen child protection programs.
7. Expand PrEP uptake in DREAMS counties.

4.3.1.2 OVC Targets and Activities

The OVC_SERV targets for OVC comprehensive, OVC preventive, and DREAMS (aged 9-17 years) were based on data reviews and analysis to identify the scope of current coverage and gaps within the current OVC sub-populations. These included COP20 targets, performance per county and IP, number of C/ALHIV on treatment, number of pregnant and breastfeeding AGYW within the PMTCT program, GENDER GBV data for age bands less than 17 years, OVC household exits and graduation, OVC aged ≥18 years completing secondary education and vocational skills training, and NACC 2020 estimates of orphans due to AIDS.

In COP21, the OVC program will continue to scale up and offer opportunity for enrolment into the OVC program to C/ALHIV, pregnant adolescents, breastfeeding young mothers and HEIs, children of KP, and children who have experienced any form of sexual violence. This means scaling up the number of OVC receiving OVC Comprehensive from 46% (330,813) in COP20 to 62% (396,866) in COP21 and reducing the number of OVC Preventive from 30% (216,000) in COP20 to 10% (66,800) in COP21 and DREAMS (aged 9-17 years) from 23% (164,559) in COP20 to 28% (136,742) in COP21.

With the enhanced integration, collaboration, and surge between the OVC, clinical, and PMTCT programs, there has been a steady increase in the number of C/ALHIV enrolled into the OVC program. The PEPFAR Kenya intervention package for HIV positive OVC follows GoK national guidelines and prioritizes viral suppression across all sub-populations. As at APR20, the OVC program had enrolled 70,898 C/ALHIV in 39 counties. In COP20, the OVC program pivoted to 25 counties and is currently supporting 65,180 (80%) C/ALHIV in priority counties with an enrollment gap of 15,908 of the C/ALHIV on treatment. To bridge this gap, the OVC and the clinical team will continue collaborating to identify, track, and complete referrals for biological children of PHLIV and biological siblings of C/ALHIV currently on ART and link them to HTS services. The OVC program will also continue to: 1) surge in high volume sites; 2) have MOUs with health facilities to ensure shared confidentiality; 3) complete bilateral referrals between the facility and community; 4) carry out comprehensive case management; and 5) participate in the multidisciplinary teams at the facility level.

In COP20, the OVC and PMTCT interagency teams jointly developed an OVC/PMTCT SOP, checklist, and implementation and monitoring process guide that will enable both the PMTCT and OVC programs to identify, track, and refer pregnant adolescents, breastfeeding adolescent mothers, and HEIs both from the facility and community levels. With this structured collaboration, there is an expected increase in: 1) enrolment into the OVC program; 2) linkages to DREAMS for the HIV negative adolescent pregnant and breastfeeding mothers; 3) monitoring and documentation of progress on uptake of interventions for HEIs, VL for their adolescent mothers, and HIV testing for AGYW.

The OVC program will continue to monitor, track, and refer OVC households through the GOK Child Protection Information Management System (CPIMS). This will include data

capture, analytics, evidence-based review to inform learning, advocacy, and planning to OVC services at national and county levels. This ensures accountability and transparency, and enhances wraparound services and linkages with other stakeholders. Through leadership from the Department of Children services, OVC IPs will continue collaborating and coordinating activities with stakeholders both at national and county levels to reduce duplication of efforts, increase reporting, and improve quality of services. This will include creating linkages and leveraging investments by GOK, county governments, and development partners (e.g. UNICEF, Foreign Commonwealth Development Office (FCDO)) in safety net programs, routine DQA, participation in Area Advisory Committees, and implementation and operationalization of the National Prevention and Response Plan (2019-2023) on Violence Against Children. Leveraging these stakeholder investments and resources will strengthen advocacy for increased technical and financial resources from county governments to support OVC.

4.3.1.3 Primary Prevention among DREAMS and OVC

In COP21, PEPFAR Kenya will continue to strengthen HIV and violence prevention among AGYW aged 9-14 years through an age-appropriate package of interventions while enhancing service layering for AGYW enrolled in DREAMS to meet their multiple needs. The OVC program will also continue reaching adolescent at risk OVCs (aged 9-14 years) and their caregivers using approved evidence-informed behavioral interventions (EBI). The OVCs will be reached through the Healthy Choices for a Better Future programs, while their caregivers will be supported on parenting and violence prevention using Sinovuyo or the Families Matter! Program. Through these interventions, it is anticipated that the boys and girls within this age group and their caregivers will acquire skills that support healthy decisions and prevent violence, as well as be better able to report, refer, and access services. Caregivers and community members will also be targeted through small group interventions to increase their knowledge and skills on how to support adolescents within their care. The program will strengthen OVC/DREAMS integration through intensified HIV and violence prevention interventions within the DREAMS SNU's by increasing the proportion of female OVC at risk of contracting HIV who complete an approved EBI.

Since the GOK launched the National Prevention and Response Plan on Violence Against Children in July 2020, the OVC program has been supporting its dissemination and implementation based on the six strategic areas identified in the plan. Activities include: 1) community mobilization; 2) support for education and life skills for children; 3) parenting skills and economic strengthening activities for caregivers and out-of-school youth; and 4) coordination activities by stakeholders (e.g. AACs meetings where children's issues are reported, addressed, and action taken). In COP21, the OVC program will continue to work with the leadership of the Department of Children Services and other stakeholders to address prevention and refer and report any cases of violence against children.

4.3.2 Children and PMTCT

PEPFAR Kenya will work closely with Ministry of Health to ensure integrated HIV services for children and women in PMTCT settings. To improve case identification, the program

will ensure line-listing of children of PBFW and testing to ascertain final HIV status. Clinical partners will work in collaboration with OVC partners to ensure all listed children are supported to get an HIV test. Further discussions with the Ministry of Health on integration in PMTCT settings will take place within the broader guidelines and policies on integration (e.g. within routine HEI screening within MCH, pregnancy intention assessment of mothers, FP provision).

VL coverage for all PBFW and HIV-infected infants in PMTCT will be enhanced and appropriate and timely measures undertaken for those with virologic failure. Psychosocial support and adherence counselling services will be integrated within PMTCT settings including specific packages for supporting children and caregivers with adherence challenges to ART or ARV prophylaxis. Challenging cases will be referred and linked to OVC for intensified case management and directly-observed therapy where feasible.

Further, the program will ensure integrated follow up of HIV-exposed-and-infected infants within MNCH settings to promote continuity of care of mother-infant pairs and successful discharge at 24 months after confirmation of final HIV status. Mobile technologies using SMS appointment reminders will be utilized to promote appointment keeping and retention. Robust defaulter tracking measures will be adopted to bring back to care mother-infant pairs lost to follow up.

Efforts will be made to support longitudinal follow up of mother-infant pairs through 18 months by adopting and expanding use of electronic modules for data collection and collation. Documentation of mother-infant outcomes from ANC throughs the delivery and postnatal periods will be tracked to ensure uptake of PMTCT, ANC, and well-baby services such as immunization and nutrition services

4.3.2.1 Children and Adolescents

In COP21, PEPFAR Kenya in collaboration with the Ministry of Health will implement the SURGE/LEAP strategies with heightened partner monitoring and support to increase the number of C/ALHIV identified and linked to care and treatment. Biological children of index clients - both male and female - will be tested as part of the ongoing index testing. Positive children will also be considered as index clients and their child-siblings and biologic parents will be offered a test.

COP21 will support violence screening and identification before and after index testing services to avoid unintended violence for these index clients. Conventional case identification among children will use different strategies for sick and well children. For sick children, COP21 will continue to support testing of all children at high-yield entry points including pediatric inpatient wards, TB units, and malnutrition clinics. Guidelines on strict adherence to the 5Cs as entrenched on the HTS guideline of 2015 will be enforced. Within the outpatient department, children will be screened for eligibility for HIV testing using an age-appropriate, pediatric HIV testing screening tool. Those eligible will be offered an HIV test. Early identification and linkage to ART for HEI will be enhanced

through optimized HEI screening, enhanced uptake of EID within 2 months of birth and enhanced mother-infant pair follow-up through longitudinal cohort tracking.

Due to high MTCT rates observed during breastfeeding, COP21 will work closely with OVC partners to follow up breastfeeding women who are newly enrolled, unsuppressed, have a history of interruption in treatment, and AGYW as a priority at household level. PEPFAR Kenya will jointly develop a checklist to aid OVC case workers in understanding what to monitor (e.g. drug adherence, nutrition/optimal weight, EID monitoring, adherence to infant feeding guidelines, and immunization). COP21 will strengthen linkage to OVC programs for CLHIV for additional. Children and adolescents who experience sexual violence will be offered a package of services including HIV prevention HTS, PEP or linkage to care if identified as positive. PEPFAR recognizes the creation of the Community PMTCT Coordination Department at NASCOP and hopes to contribute to broader community interventions through the broader strategic plan and other stakeholder engagements.

COP21 will support identification of HIV-infected adolescents through SNS, HIV self-testing, and peer-led approaches. Enhanced psychological/mental health support systems will be provided for adolescents who test HIV positive. Sexually active adolescents will be offered assisted partner notification services (aPNS). Peer networks such as those developed through Operation Triple Zero (OTZ) will be utilized to obtain index cases for social network testing. COP21 will support the use of HIV self-testing to identify adolescents and use peers to distribute the HIV self-test kits and link the positives back to facilities for confirmation. Empowered OTZ champions will be utilized to facilitate ethical index testing of sexually-active AYP, line listing of contacts and linking them testing. OTZ champions will also be used to pass correct information on HVST and facilitate feedback to facilities of test outcomes for AYP tested, linking those who test positive to the facility for confirmatory tests.

PEPFAR Kenya supports appointment scheduling that factors in school calendars for school going adolescents. In order to accommodate in-school adolescents, COP21 will also support facilities to provide flexible hours for HTS, including Saturday and school holidays for in-school youth. The OTZ champions initiative has comprehensive treatment literacy material for adolescents and young people and provides information on treatment, adherence, effective participation, leadership, and positive outlook. These modules not only provide AYP with information on treatment, but also empowers them to be leaders and fosters self-health management. Through PEPFAR Kenya IPs, there are TWGs at county level that bring together Ministry of Health, Ministry of Education, and PEPFAR partners to steer support for young learners living with HIV (YLLHIV). The initiative includes training of school gate keepers to support YLLHIV in schools, promote stigma-free learning institutions, and support YLLHIV with treatment retention and provision of DOTS where applicable.

COP21 will support collaboration with PMTCT to identify pregnant and breastfeeding adolescents and link them to Operation Triple Zero in a way that caters to the pregnant adolescent. PEPFAR Kenya team has expanded OTZ to include support for adolescents and young people living with HIV (AYPLHIV) who are pregnant and breastfeeding. This component of OTZ is called OTZ-Plus which is geared towards achieving the three zeros of OTZ (i.e. zero missed appointments, zero missed drugs, and zero viral load, plus zero MTCT. The OTZ plus package will include 1) maternal HAART and infant prophylaxis adherence; 2) case management; 3) treatment literacy; 4) positive outlook; 5) infant feeding; 6) SRH and mental health support; 7) OTZ Plus clubs; and 8) linkage to OVC for comprehensive support in the community. Recency testing data will be used to map transmission in hot spots to improve targeting of HTS. Adolescents on the OVC platform will be screened for risk using the girl roster tools and the HIV screening tool with appropriate linkages to HTS and partner testing. The HIV-negative PBFW in sero-discordant relationships or with partners of unknown HIV status will be offered PrEP as part of the package of care.

Finally, through targeted messaging to caregivers and parents, PEPFAR Kenya will support demand creation for pediatric and adolescent HTS. COP21 supports utilization of social media platforms to reach out to adolescents with messages on HTS and use of faith-based platforms to promote messages on pediatric and adolescent HTS.

4.3.2.2 Prevention of Mother-to-Child Transmission (PMTCT)

PEPFAR acknowledges the role of Ministry of Health at both national and county levels, engaging with both parties during annual COP planning, implementation, and review. At county level, the IPs work directly under county leadership, and coordinating activities through the county health departments. PEPFAR Kenya will continue to provide technical support and direct PMTCT service delivery through IPs. In FY22, PEPFAR Kenya will continue working closely with counties to strengthen facility-community linkage to increase PMTCT demand creation around maternal HIV testing, POC testing for HEI, and continuity of treatment for HIV positive women and their infants. In an effort to reduce Kenya's persistently high MTCT rates, PEPFAR will also focus on: 1) improving VL testing coverage and viral suppression; 2) EID coverage for infants aged <2 months; 3) prevention via use of PrEP; 4) AGYW-specific interventions; and 5) detection of incident infections among PBFW.

To realign the program and achieve COP21 (FY22) targets, PEPFAR Kenya will also provide differential support and a package of services based on SNU unique needs. In FY20, Kenya achieved 84% of PMTCT_STAT, 87% of PMTCT positive and 91% of PMTCT_ART targets compared to 89%, 83% and 83% respectively in FY19. The PMTCT need in COP21 is estimated at 55,340, higher than the COP20 country need of 54,516. Of those attending first ANC, 99% knew their HIV status while 99% of those identified as HIV positive initiated ART. Out of the 55,141 infants tested, 75% were tested at less than two months against a target of 95%. Total of 1,935 (2.7%) were identified PCR positive and 89% linked to treatment.

For COP21, FY20 achievements, projected FY21 performance, background of partner performance, and local demographic context was used to generate PEPFAR targets by SNU and IP. The following data sources were used to determine PMTCT targets: preliminary Spectrum 2021 estimates, PEPFAR MER data (APR2020), and FY21 Q1 data. Using these sources, It is estimated that 84% (1,068,205) of pregnant women will seek services at PEPFAR-supported sites in 40 counties out of whom 96% (1,024,481) will receive an HIV test or know their HIV status. The PMTCT STAT_POS targets are generated from national EPP Spectrum that estimated PMTCT need at 54,516. In FY22, PEPFAR Kenya will target 96% (52,557) of the national PMTCT need in all supported sites, which includes 100% of the known positive women on ART (39,758), and 100% of the newly-diagnosed positive women initiated on ART (13,456).

PEPFAR will retain COP20 of 5,340 targeting a coverage of 30%. PrEP PMTCT targets have been estimated by focusing on HIV negative pregnant women at continuous risk of HIV acquisition. They were calculated at SNU level as follows: (NP+Negative formed the denominator. The rate of infection was then generated by [HIV incidence x negatives] = {(NP/NP +Negative) x Negative}. Using the SNU-specific incidence for women of reproductive age (HTS positivity) and multiplying by the negatives gave a target of 17,348 PMTCT mothers eligible for PrEP.

As PrEP is a new activity started under COP20, focus has been on building capacity of health care workers to provide PrEP in the PMTCT setting. Kenya does not have a comprehensive policy that allows provision of PrEP to be given to adolescents below the age of 18 years, including those who are pregnant or breastfeeding. In COP21, PEPFAR will work with the GOK to review the policy barriers hindering AGYW from accessing PrEP, as well as support PrEP for eligible HIV negative women, including PBFW.

EID coverage remains a priority in COP21 with an emphasis on early testing of HEI age <2 months, timely return of results to caregivers, and prompt linkage to treatment for HIV positive infants. This will be achieved through: 1) enhanced continuity of treatment; 2) post-ANC 1 maternal retesting; 3) HEI screening at immunization; and 4) optimized early referrals. At least 95% (51,314) of expected HEIs will be targeted for infant virologic tests, of whom 95% (43,208) will be targeted to receive an EID test at age < 2 months. The POC platform will be expanded from 6 to 10 for regions that report high numbers of positive infants, as well as for areas that have poor access to the conventional EID testing and long turnaround times for results. PEPFAR Kenya continues to track the time taken from sample collection to results being given to the caregiver and improve on any gaps identified. At least 95% of HIV positive infants identified in PMTCT settings will be linked to treatment.

The spectrum model for MTCT indicates that approximately 47% of new infections are due to ART dropouts, among which 32% occur during pregnancy. The program proposes to improve continuity of treatment of mother-infant pairs by developing client-centered high risk categorization and management with a focus on: 1) newly positive women; 2) improved

ART cohort register documentation; and 3) reporting and data use. Mentor mothers will be supported to structure peer support skills including messages of hope offered to enhance uptake and continuity of PMTCT interventions. Institutionalization of structured exit interviews including focused client group discussions will be carried out to establish and address modifiable socio-economic and cultural/religious barriers.

Late presentation after 6 weeks has been attributed to weak tracking in the context of a leaky cascade and post-ANC 1 new positives causing a delay in HEI case identification. HEI case identification in infants aged <2 months was 85% in FY20 Q1. In order to reach the 95% target, PEPFAR Kenya will: 1) optimize the use of appointment diaries and map expected date of delivery (EDD) and expected HEI at 6 weeks; 2) review case management in PMTCT and revamp mentor mother scope; and 3) enhance case-based management at site level to increase retention. All HEI will be longitudinally followed-up as a cohort until their status is determined. Site-level processes and outcomes that include client characterization and bottleneck analysis for sites recording high PCR positives will be fast tracked and additional mentorship and CQI support offered in collaboration with county governments. Discussions will continue at national level to seek guidance on how best to document HEI screening status in the immunization registers as part of optimized HEI identification.

Program data indicates that there is low VL coverage and suppression rates among newly identified HIV positive PBFW compared to known positives. Using the SGAC denominator of KP on ART, this translates to low coverage. Whereas documentation may be the issue, it is also possible that health care workers are not adhering to guidelines. In COP21, PEPFAR Kenya will conduct a data audit from the ART cohort register to confirm documentation and coverage, followed by activities to harmonize the process and measurements (VLC and VLS) that can extend cohort data reporting beyond site level. PEPFAR Kenya will work with NASCOP to align the VL testing algorithm to the new WHO recommendations. The program will also work with the GOK to develop and disseminate PMTCT specific U=U and TLD messaging that will include VL literacy.

To boost retention and VL monitoring, high-risk clients (viremia, treatment decliners/defaulters, newly diagnosed positives, AGYW) and stable post-ANC clients, will be categorized and streamed through differentiated care models. New positives will be paired with a clinic buddy for the initial six months after diagnosis. The existing high VL clinics in MCH will be optimized to fast track women with suboptimal VL. PEPFAR Kenya will continue to support targeted community support through defaulter tracing and home visits via facility peer supporters or community health volunteers linked to the facility.

Forty five percent (45%) of ANC clients are AGYW, and they contribute 39% to new HIV positive women identified. They also account for 33% of incident infections post ANC. PEPFAR Kenya will work with NASCOP to establish a PBFW-AGYW specific package of care. PEPFAR Kenya will also work towards prevention and detection of incident infections among PBFW with a special focus on AGYW that will include referrals to OVC and

DREAMS programs. Maternal retesting will be optimized with early enrolment into care. HIV negative high-risk assessment and support including PrEP will be rolled out. Documentation will be established to collect this new indicator under PMTCT.

With the rollout of MMD in the ART clinics, pregnancy intention assessment and support, including family planning (FP) services, will be enhanced to reduce unmet need for FP among HIV positive women of reproductive age. Additional services will include: 1) male involvement strategies such as safe and ethical index case testing; 2) provision of HIV self-testing kits; 3) referral of negative male partners and infant males for VMMC; 4) discordant couple counseling; and 5) risk reduction support and use of PrEP for HIV negative sexual partners.

To optimize longitudinal and outcome monitoring for mother-baby pairs, a PMTCT EMR module which was finalized in COP20 will be rolled out for all EMR-enabled sites with expected data transmission into the national data warehouse. Additionally, planned review of guidelines and tools is anticipated to align documentation, reporting, and utilization at all levels. The PEPFAR Kenya MNCH team will engage NASCOP to establish regional county clusters for eMTCT stock taking, cross learning, and progress monitoring. Lab networks will be equally strengthened and use of the national EID/VL dashboard will be optimized towards increased and timely access of results for client management.

4.3.3 Key and Priority Populations

In COP21, PEPFAR Kenya will focus on optimizing KP population coverage at the national level by leveraging both geographic- and population-specific rationalization with other donor programs and accounting for the full prevention and treatment cascade. Geographically, COP21 seeks to reach 95% of all KP subtypes in Kenya with HIV prevention interventions, identify and link to treatment 95% of KP living with HIV, and ensure viral suppression amongst 95% of all KP on treatment within the PEPFAR SNUs.

Through the leadership of the Ministry of Health, KP programming was geographically rationalized between PEPFAR and GF in 2019 to increase efficiencies. The COP21 plan is a continuation of COP19, reengineering of the KP program with a focus on optimizing coverage and improving program quality to achieve 95-95-95 by 2025. The program will continue to collaborate with the Ministry of Health through the National AIDS and STI Control Program's KP Technical Support Unit and other key stakeholders including KP CSO consortia, GF, and UNAIDS to continuously improve quality and performance of the program.

In COP21, PEPFAR Kenya will continue to address key programmatic gaps in the prevention and clinical cascade among KP to achieve HIV epidemic control by leveraging transformative health systems investments made in FY20. These investments include activities supporting: 1) MSM coverage; 2) case identification; 3) overcoming low yield; 4) optimal linkage of identified KPLHIV to treatment; 5) continuity of treatment; and 6) VL coverage

In COP21, 95% of FSW, MSM, PWID, and TG based on the NASCOP 2018 KP size estimates will be targeted in 24 counties categorized as high and medium burden based on the Spectrum HIV Estimates of 2021. In COP19, Ministry of Health rationalized the KP program, including PWID. PEPFAR Kenya will continue programming as rationalized by Ministry of Health. PEPFAR Kenya will also continue to program for PWID in Kisumu and Kiambu Counties. In addition, in COP 21, PEPFAR Kenya will support service delivery gaps noted in Nairobi County.

In FY20, there were immense strides made in TG programming including working with Ministry of Health and CSOs to develop the National Transgender Guidelines. In COP2021 PEPFAR will continue with HIV prevention and treatment programming for the TG population in Nairobi, Mombasa and Kisumu counties where significant TG populations were mapped to reach 95% of the TG population based on KPSE 2018. PEPFAR will work through IPs in supported counties to ensure that trans persons access services and strengthen collaboration and working relationships with TG-led organizations in line procurement regulations.

Achieving sustained epidemic control will be predicated on achieving optimal coverage of both the prevention and clinical cascades along the 95-95-95 cascade. Across all the KP sub-types, COP21 will scale up the peer outreach model at KP hot spots, safe spaces, and integrated public health facilities to ensure optimal reach and program sustainability. The program will scale up safe and ethical index client testing and social network testing strategies (SNS) to increase case identification with a specific focus on reaching new and younger MSM, FSWs, PWID, and TG populations. Only safe and ethical index case testing certified sites will be allowed to offer index testing to KPs based on safe and ethical site assessment in COP20 going forward. All KP sites offering index testing have strategies to improve service uptake including: 1) engaging additional peer leaders and peer educators to address the peer ratio; 2) health worker training to offer KP friendly services; 3) increased targeted outreaches; and 4) use of social media.

KPs will be provided with a core package of services that includes: 1) condoms and lubricant promotion and distribution; 2) targeted HTS based on risk; 3) linkage and timely initiation on ART for those testing positive; 4) TB screening and treatment; 5) provision of PrEP and PEP for all eligible KPs; 6) screening and treatment for STIs; 7) peer education and outreach services; 8) risk reduction behavioral interventions; 9) violence prevention and post violence care; and 10) alcohol and substance abuse counseling including U=U messaging. In COP21, PEPFAR will work with Ministry of Health and CSOs to revise and include event-driven PrEP for MSM in the National Key Populations Guidelines.

In COP21 there will be intensified efforts to institutionalize innovations implemented through the KP Investment Fund (KPIF) to achieve the 95-95-95 goals by 2025. To achieve the 1st 95, HIV testing will target newly enrolled KP and outreaches at new hotspots, use of innovative social network testing strategies, and safe and ethical index client testing to

increase case identification. Self-testing, including virtual networks platforms for MSM communities ,will also be promoted and offered.

For the 2nd 95, community ART initiation through integrated outreaches, same day ART initiations, shift to TLD, and a case management approach will be scaled up. Continuity of treatment will be enhanced through a robust appointment management system and defaulter tracking using a KPLHIV tracker with regular reporting of net new clients on ART and current on ART, accounting for all net losses.

COP21 3rd 95 strategies include scale up of U=U messaging for KP and a case management approach both at facility and community level. Differentiated care including MMD that enhances continuity of treatment will be scaled up. PEPFAR Kenya will support facilities to explore and implement extended hours services to KPLHIV across the treatment cascade. Tracking of KP viral suppression by typology will be strengthened to ensure optimal uptake of VL testing and interventions for viral suppression. In COP21 PEPFFAR Kenya will strengthen integrated sample networking to improve access to VL testing. TB screening among KPs living with HIV will be continuously tracked and all presumptive cases investigated with clients found positive initiated on treatment. Clients who screen negative for TB will be initiated on TB preventive therapy (TPT) based on eligibility and all those currently on ART will be continuously screened to ensure TPT completion. In COP21, IPs will work with GOK, county governments, and other stakeholders for referrals for nutritional support for vulnerable KPs.

In COP19, PEPFAR Kenya received funds from the KPIF to accelerate KP programming to achieve 95-95-95 among KPLHIV including innovations for preventive services. This was successfully implemented in COP19 and COP20 with several key innovations to accelerate progress towards targets. In COP21, despite no additional funding from KPIF, PEPFAR Kenya will institutionalize innovative approaches that include: 1) SNS for case identification; 2) the KPLHIV tracker to scale up viral uptake and suppression; 3) psychosocial support to promote retention and treatment adherence; 4) continued funding for KP-led CSOs; 5) continued capacity building of sub-grant CSOs; and 6) improved coordination of violence prevention and response.

In collaboration with Ministry of Health and CSOs, PEPFAR Kenya will address barriers to launch and scale up mobile PWID medication-assisted therapy (MAT) services to increase access to high-risk injecting users unable to access the established static sites. PEPFAR Kenya will engage the Ministry of Health to provide staff to MAT clinics to increase enrollment and uptake of services as well as engage PWID CSOs to mobilize, refer clients for MAT, and provide adherence counselling to MAT clients. PEPFAR Kenya will review quality of services in all MAT-supported sites and work with IPs, Ministry of Health and county governments to address any gaps in service delivery and strengthen CQI initiatives. PEPFAR Kenya will continue to support counselling and screening of women who use drugs for prevention and treatment services—including reproductive health—and refer

appropriately. PEPFAR will continue to provide gender-disaggregated data for MAT and HIV prevention and treatment services.

In COP20, there was progress towards roll out of the KP module in the Kenya EMR in addition to improved reporting rates in the KHIS for KP. The re-engineering of KP programming initiated two years ago under the KPIF led to the creation of a framework for ongoing improvement of KP EMR and M & E, along with operational definitions of KP typologies aligned as much as possible to national, WHO, and PEPFAR guidance to the extent possible.

In COP21, PEPFAR will continue supporting and building a robust and comprehensive M&E system required to ensure that programs are up to date and can intervene through real time use of data for decision making.

In COP21 PEPFAR will continue to support the military and fisherfolk as vulnerable populations with comprehensive HIV prevention and treatment services. Fisherfolk in the Great Lakes region of Western Kenya constitute a vulnerable population with an estimated 23.4% HIV prevalence (KEMRI Asembo Fisherfolk IBBS, 2016) and have a need for intensified interventions for HIV prevention and treatment. Military and uniformed services are high risk and need to be reached with services.

COP21 will support sensitization of county government health teams, community workers, and local administration (e.g. chiefs, police) to ensure a safe environment for KP programs. This will also include support for KP-led GBV/IPV prevention, documentation, response, and linkage to treatment.

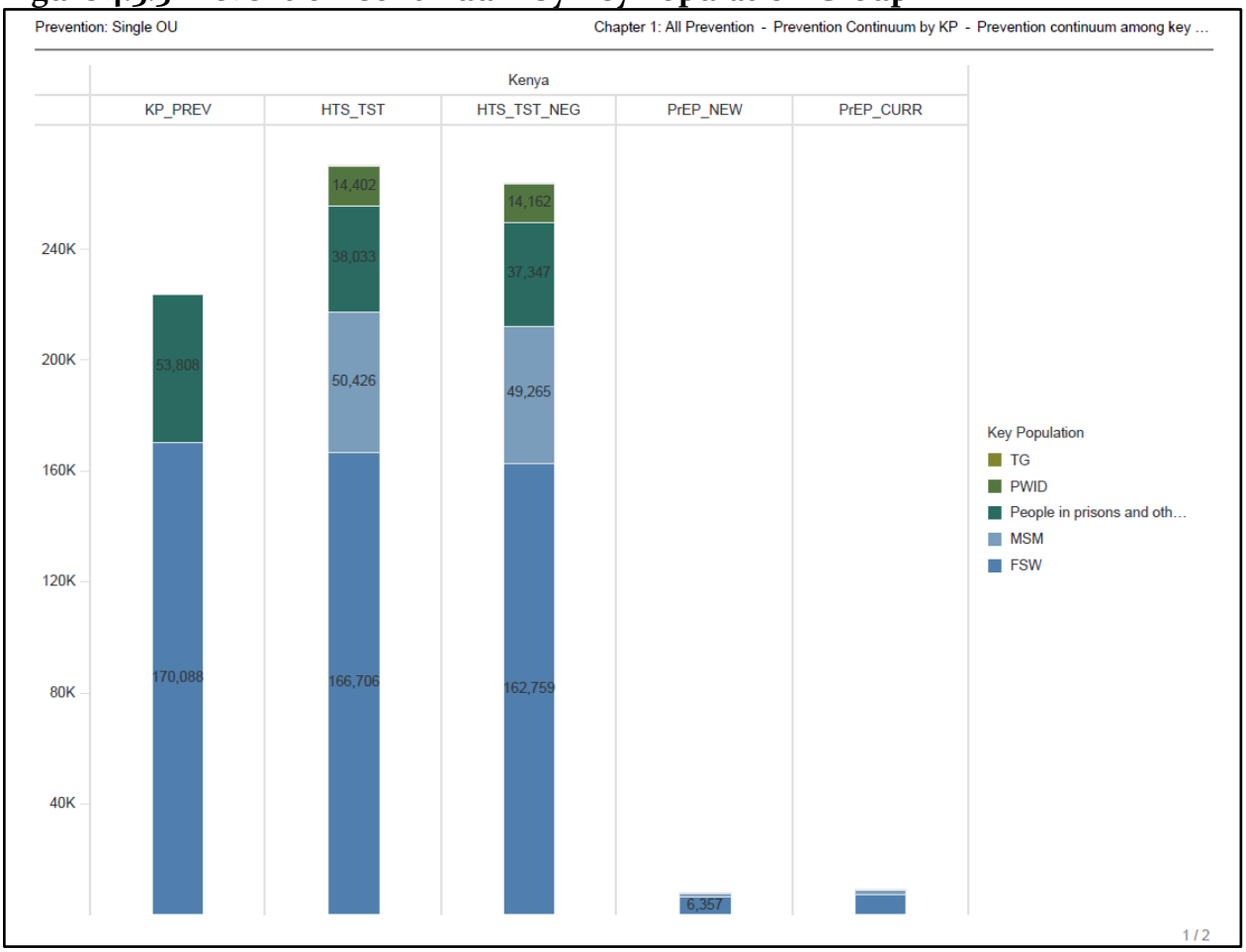
In COP21, PEPFAR will continue to build strong partnerships with the KP Consortium and other KP-led CSOs including TG organizations to ensure the KP program is owned and managed by KP for accelerated epidemic control. In COP21, PEPFAR will continue to strengthen and sub-grant KP-led organizations to expand community-led KP service provision. KP-led standalone and integrated drop-in centers (DICE) will be supported including provision of ART at all eligible DICES alongside scale up of innovative case identification and wrap around comprehensive services. The program will coordinate with the KP community to offer health care worker sensitization at KP select referral public health facilities to provide friendly and dignified integrated KP services. PEPFAR will ensure that there is meaningful engagement of all stakeholders including the KP community in any program transitions.

A human rights-based approach will be adopted to ensure that all interventions address stigma and discrimination. Through meaningful involvement of KPLHIV, PEPFAR Kenya will address leaks in the prevention and treatment cascade through improved linkage, adherence, and patient literacy.

In COP21 PEPFAR targets to reach 136,257 FSWs, 80,064 MSMs, 1635 PWIDs (with 7936 on MAT), 64,800 inmates and prison populations, and 1641 TG with HIV prevention and treatment services in a total of 24 HIV high- and medium-burden counties. The program will also target 64,800 fisherfolk and military.

In response to COVID-19 challenges, IPs will offer support to healthcare workers, peer educators, and other KP service providers with PPE and supplies and ensure site-level infection prevention and control measures are adhered to in line with Ministry of Health COVID-19 regulations. PEPFAR will work with national and county governments to ensure continuity of quality service provision to ART clients including KPLHIV. This will include MMD of ART, innovative psychosocial support group activities, and facilitation of service providers to offer uninterrupted service provision.

Figure 4.3.3 Prevention Continuum by Key Population Group



Source: Kenya OU dossier, Prevention chapter, April 27, 2021; From FY19 Q1-Q4, FY20 Q1-Q4; FY21 Q1.

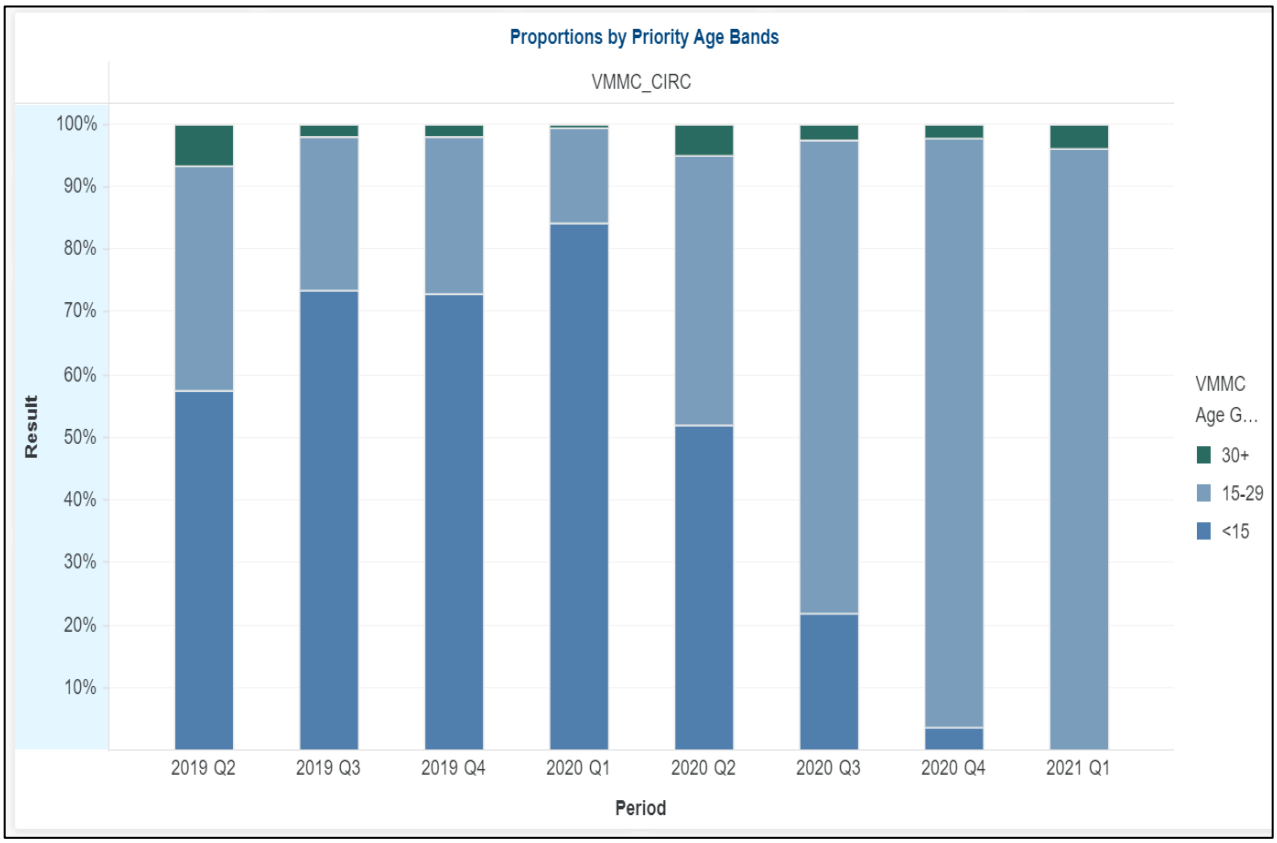
4.3.4 VMMC

The PEPFAR program in Kenya currently supports implementation of VMMC in 10 out 47 counties. From its inception in 2007, VMMC has been implemented in counties within the Western Region, parts of the Rift Valley, and Nairobi where the majority of culturally non-circumcising ethnic groups live. In COP21, PEPFAR will support ongoing initiatives to transition the VMMC program to the Ministry of Health. PEPFAR will continue to support VMMC service delivery in 7 counties (listed in Table 4.8.2). The overarching goal is to achieve 80% male circumcision prevalence among men aged ≥15 years and above in 5 counties whose coverage is below 80% (Kisumu, Siaya, Homabay, Migori, Turkana).

Additionally, despite their overall high MC coverage of > 80%, Nairobi and Nandi counties will receive service delivery support for focal areas inhabited by migrant, non-circumcising ethnic groups. Three counties (Busia, Nakuru, Kericho) whose service delivery support was transitioned to Ministry of Health in COP20 will continue to get above site support covering service quality assurance and coordination in COP21. Lessons from a recently concluded VMMC sustainability pilot funded by PEPFAR/CDC will be applied in progressive transition of the entire program towards full country/Ministry of Health leadership and financing. Like COP20, COP21 aims to achieve 55,000 circumcisions among men aged 15 years in COP21. VMMC will be offered as a standard package of services including excision of the foreskin through dorsal slit or ShangRing as the preferred methods.

New areas of emphasis for VMMC in COP21 to address the COVID-19 pandemic will include: 1) virtual post-circumcision follow up to limit provider client-contact; 2) physical distancing at VMMC sites; and 3) client-centered demand creation without large group community meetings. VMMC will be offered routinely to males aged ≥15 years who test HIV negative in HTS at clinical and community settings. VMMC will also be used as a platform for providing other health services to males including TT vaccination and identification and management of genital malformations. PEPFAR funding will also support management of severe adverse events and trainings at the VMMC Centers of Excellence at the regional referral hospital in Kisumu city (JOOTRH) and Homabay County Referral Hospital will continue in COP21.

Figure 4.3.4 VMMC Quarterly Results by Age Bands for Kenya: 2019 Q2 – 2021 Q1



Source: Kenya OU dossier, VMMC chapter, April 27, 2021

4.3.5 Gender-Based Violence

In COP21, PEPFAR Kenya will continue to address gender-based violence (GBV) and inequality across the HIV cascade. The program will address the following four priorities:

- Address intimate partner violence (IPV) in the context of PrEP, index testing, and care and treatment (routine and clinical enquiry)
- Provide post-violence clinical care services at HIV care and treatment sites
- Improve linkage between community-based HIV and GBV prevention interventions and clinical post-GBV care services
- Improve monitoring of GBV case identification, prevention, and response activities

All certified sites conducting HIV index testing will be supported by COP21 to conduct mandatory inquiry for IPV on all clients offered aPNS. Providers will be expected to duly complete the aPNS registers indicating that enquiry of IPV has been done. Similarly, all PrEP sites including DREAMS and care and treatment sites will be expected to conduct inquiry into IPV at both ART initiation and at follow-up clinical visits. Subsequently, all sites will be required to offer first line support (LIVES).

Clinical sites will integrate HIV and GBV clinical services. They will offer the full minimum package of post-violence clinical care (as defined by the GEND_GBV MER indicator) and referrals for local GBV response services. The program will implement the GBV quality assurance tool and apply the SIMS standard at all sites to assess the quality of post-violence clinical care services.

The DREAMS, OVC, and FBO and CSO programs will sensitize frontline staff and train facilitators who will administer screening and enrollment as to how to ask about violence. Additionally, staff will be re-oriented on their response as well as on how to provide first-line support (LIVES) and how to immediately refer to clinical and/or non-clinical GBV response services. Referral cards and information that will assist survivors to access GBV response services will be made available through facilitators and program staff. Survivors who test negative will be linked to HIV and GBV prevention programs.

All IPs will be monitored on GBV case identification, prevention, and response on a monthly basis. MER and custom indicators that measure gender norms change activities will be integrated into IP work plans. Quarterly reporting will be required from all IPs. Planned site visits will take place that will prioritize the highest volume sites and poor performing sites. At clinical service delivery points, clinicians will be required to enquire about GBV during ART initiation and routine clinical care. Survivors will be supported and referred to GBV clinical care.

4.4 Additional Country-Specific Priorities Listed in the Planning Level Letter

This information is covered in Section 4.1-3 above

4.5 Additional program priorities: COVID-19 PEPFAR Kenya responses

PEPFAR Kenya is requesting $18,250,599 from America Rescue Plan Act (ARPA) funding to mitigate and repair COVID-19-related program impacts. The full ARPA proposal can be found in Appendix E. ARPA funding requests are across the following areas:

Infection Prevention and Control (IPC)

ARPA funds will support comprehensive IPC in PEPFAR-supported sites aimed at protecting staff and patients against COVID-19 and enabling them to continue providing essential services during the pandemic. Funds will also prevent infections among vulnerable patients, thereby reducing morbidity and mortality. IPC activities include site-level engineering, administrative, and environmental inputs to reduce COVID-19 infection, including PPE for health workers and patients, minor infrastructure changes, procurement of tents, and hand hygiene support. Additional funding is requested on behalf of IPC in prisons and military camps. Kenya prisons are congested at 170% of design capacity, and quarantine facilities at 300% of design capacity. Social distancing is impossible and outbreaks with attack rates of >90% have been reported. Funds will expand quarantine facilities at these sites and create “green zones” for protection of the elderly and other vulnerable individuals. Prison wards will be renovated, tents supplied, and capacity built in the Kenya prisons’ industry for sustainable in-house production of reusable masks.

COVID-19 Testing and Epidemiological Surveillance
Congestion and lack of space at Kenyan prisons make it difficult to hold inmates with COVID-19 in isolation. Specimens from the 129 prisons are also networked to KEMRI and other labs for testing, and the long distances, large turnaround time, and shortage of kits and PPE are associated with a delay in testing and receipt of results. Additionally, the military is a highly mobile population. Rapid testing and isolation of infectious cases are needed to prevent COVID-19 transmission among these communities. ARPA funds will be used to procure rapid antigen-test kits and train uniformed laboratory staff on use of Ki-Rapid testing. The activity will also strengthen military-supported COVID-19 laboratory testing platforms. Funds will help scale up testing coverage among health workers and beneficiaries in these enclosed settings and enable immediate response to cases identified.

Additional funding is requested for surveillance activities. Although PLHIV in Kenya constitute a population at increased risk of poor COVID-19 health outcomes, counties do not routinely report on COVID-19 testing or outcomes among PLHIV. This activity aims to: 1) improve routine capture of HIV status and other co-morbid conditions (e.g. diabetes, hypertension) by existing MOH COVID-19 case investigation forms in all PEPFAR-supported counties; 2) support counties to use data on HIV status to report on COVID-19 test positivity, attack rates, case fatality rates, and severe outcomes among PLHIV; and 3) use HIV/COVID-19 situational reports to target COVID-19-related health interventions among PLHIV served by PEPFAR Kenya (e.g. outreach/messaging around health benefits of vaccination, masking and social distancing, sustained ART, enhanced clinical management of PLHIV with other co-morbid conditions, etc.). Funds will support rapid assessment of data quality in the standardized MOH COVID-19 case investigation tool, with a focus on completion of the HIV and other co-morbidities fields. Funds will also go to conduct training and capacity building for improved routine data collection for PLHIV tested for COVID-19, and technical support to all PEPFAR-supported county governments and partners to analyze and use this data for a public health response.

Supply Chain
Challenges in timely availability of commodity data and poor reporting due to utilization of manual records have constrained planning and monitoring of the supply chain. ARPA funding will be used to enhance national supply chain end-to-end data visibility and improve last mile logistics for commodity distribution. Enhancing end-to-end commodity data visibility involves strengthening commodity data acquisition, improving reporting, and supporting visualization and utilization of this data through appropriate dashboards. Last mile logistics will be strengthened through network optimization and implementation of an electronic proof of delivery system to reduce distribution turnaround time and improve accountability. These activities address COVID-19 commodity logistics challenges, mitigate the effects of COVID-19 on the supply chain, and improve overall efficiency.

Laboratory

PEPFAR-supported labs have complemented COVID-19 testing, putting extra pressure on infrastructure and manpower. ARPA funds will be used to facilitate availability of timely testing services and an efficient return of both HIV and COVID-19 results to clinicians. The support will enhance safety to lab personnel who are at a higher risk of infection during specimen handling in the labs. It will also support procurement of additional POC VL and DBS VL testing commodities to mitigate against stock outs. The activity also aims to enhance cold chain storage capacity and enhance waste management in PEPFAR-supported labs, and provide trainings on testing procedures, QA, and biosafety to support equipment multiplexing for HIV/TB/SARS- Cov2. The funding will enhance HRH support through additional LOE to ensure seamless testing services and timely return of results.

Repair of Program Injury

Community Interventions – Continuity of Treatment & Case Finding

The PEPFAR Kenya experienced major challenges due to COVID-19 travel restrictions, as well as IPC requirements. Partial lockdown of the country resulted in job losses and relocation to rural areas, resulting in limited access to ART clinics and treatment interruptions among clients. These restrictions impacted critical program activities including psychosocial group meetings and physical tracking and tracing efforts. ARPA funds are requested to support client-centered innovations for enhanced adherence and continuity of treatment, with a focus on expanded DSD models including MMD, DDD, and case management. This will be implemented through: 1) peer-to-peer drug distribution channels; 2) community ART pick up points; and 3) enhanced community ART groups led by experienced and stable recipients of care with psychosocial support systems to minimize treatment interruption and enhance retention. The resources will be used to expand client community drug delivery points such as: 1) community mobile dispensing points; 2) collaboration with private chemists to act as pick up points; and 3) logistics support to CHWs for drug distribution in communities (bicycles, drug backpacks, packaging materials, and transport reimbursement). Funding will go towards supporting additional clinics in provision of flexi/extended hours. Another pillar of the COVID-19 response is minimizing interruption of services. COVID-19 has resulted in a reduction in case identification. There is a need to accelerate case identification and linkage to HIV treatment and prevention services to close the gaps that resulted in facility-based service delivery interruption, thus slowing down progress toward epidemic control. ARPA funds are also requested to accelerate distribution of HIVST kits among underserved key and vulnerable populations through direct targeting using peer educators, as well as to support linkage to HIV treatment and prevention services.

Prevention Programming (GBV, AGYW, KPs, Staffing, and Prisons)

Funding is requested to sustain demand creation for service uptake, maintain HIV service delivery, and enhance program capacity to cope with the negative effects of COVID-19 (e.g. increased cases of GBV and socioeconomic vulnerability among PEPFAR program beneficiaries especially AGYW and OVC). This activity supports: 1) mass and social media campaigns (as alternatives to discontinued in-person community campaigns; 2) virtual provider-client contact for primary service delivery and follow up; and 3) boosted program

capacity to cope with COVID-19-related increases in GBV and economic vulnerability among AGYW and OVC. Funds will also support engagement of temporary personnel to maintain service delivery when regular staff are off duty due to COVID-19 exposure and support COVID-19 mitigation measures in HIV prevention program for prisons.

MNCH - PBFW

Restrictions on physical gatherings and curfews have increased cases of GBV and mental health needs among PBFW. ARPA funding will support adherence and psychosocial support for PBFWs, helping to address mental health issues arising from COVID-19. Mentor mothers will be recruited and provided phones and airtime/mobile data to enable them stay connected with program support teams and beneficiaries. Adherence support for PBFW through SMS reminders and virtual support groups to address mental health issues arising from COVID-19 will be provided, and outreach staff (e.g. mentor mothers and case managers) will be supported to work remotely.

Cervical Cancer

One immediate negative impact that COVID-19 has had on PEPFAR programs in Kenya is on the dramatic decrease in the number of women who accessed cervical cancer screening services supported by the PEPFAR Go Further initiative. Data show that, in nearly all counties in Kenya, the number of HIV-positive women on ART screened for cervical cancer dropped by more than half between 2019 Q2 and 2020 Q4. The reasons for this decrease include COVID-19-related restrictions in movement and transport, reduction in clinic services (especially during COVID-19 surges), and fear of attending clinics in person. ARPA funds will be used to implement the use of HPV self-sampling and mitigate the observed negative impact of COVID-19 on cervical cancer screening programs funded through the PEPFAR Go Further initiative. Funds will also be used to support the design of a cervical cancer screening registry using mobile phones to contact women to: 1) provide screening results; 2) link to follow-up services; 3) provide reminders repeat screening; and 4) reduce treatment interruption after abnormal screening result, thus maximizing the number of women linked to appropriate treatment while minimizing exposure to COVID-19 from visiting a health facility. All women accessing self-screening will be tracked across the cascade and outcomes documented and compared to the women screened using VIA.

Mental Health

While services are in place to offer mental health support to health workers at both the national and county levels, it is unclear if these services are reaching PEPFAR-supported health care staff and mental health support for patients is limited. This activity aims to increase awareness of existing services, facilitate access to services by PEPFAR's health workers and patients, and fill critical gaps in mental health services for vulnerable populations. Support will target both national and county levels based on the COVID-19 burden and incidence in PEPFAR-supported counties with COVID-19 cases >2,000 (Nairobi, Mombasa, Kiambu, Nakuru, Uasin Gishu, Machakos, Kajiado, Kilifi, Busia, Kisumu, Kericho, Meru). This activity will ensure health worker staff and patients have access to critical mental health services as they continue to provide and receive HIV

services against the backdrop of the ongoing COVID-19 pandemic. National IMs will provide policy and coordination support between national and county governments to support interventions and develop mental health programs and materials to ensure wide coverage. IPs will work with county teams to establish existing mental health support needs, hire short-term psychologists, facilitate the provision of existing services, and enable access to the services by the targeted beneficiaries.

TB Case Finding

Prior to COVID-19, Kenya had a 60% TB case detection. TB case finding declined 25% from the first COVID-19 case notification, with slight recovery afterward. This decline is related to the decrease in OPD attendance associated with a perceived increased risk of COVID-19, the overlap of TB and COVID-19 symptoms, and quarantine of suspected COVID-19 cases. There is an urgent need to improve case detection to prevent reversal of the gains made over the past two decades while addressing the COVID-19 pandemic within PEPFAR-supported programs. Lessons learned from CDC pilot projects in Nairobi will be used to support MOH development and scale-up digital tools for TB/COVID-19 case-finding, TB case holding, and remote monitoring for optimal treatment outcomes. TB case finding will be monitored monthly, and it is estimated that this activity will increase TB case finding by 10% relative to FY20 achievements. Effort will be placed on refocusing clinicians' efforts beyond COVID-19 to improve processes for TB case finding, including TB and COVID-19 screening, contact tracing, and community TB treatment initiation and follow-up. TPT and TB treatment MMD will be scaled up beyond the Nairobi pilot. Optimal IPC and high-level county government commitment will be secured, and TB-specific CHMT support supervision conducted to strengthen TB activities

4.6 Commodities

Funding for commodities continues to be highly volatile, with the contribution to the overall budget by PEPFAR, GF, and GOK significantly fluctuating year-by-year. Under the leadership of NASCOP, one national supply plan has been developed from which all funders (PEPFAR, GF, GoK, CHAI, GoK/CPF) have committed funding to ensure that there are no gaps for any commodities. In FY21/22, PEPFAR will support 42% of Kenya's total HIV commodities down from 53% in FY20/21; GF will cover 38% up from 36%, and GOK 20% up from 11%. Projections of FY22 commodity requirements against available funding show a funding gap of less than 15%; however, the magnitude of the deficit, if any, is dependent on target achievement across the various program components. A final Kenya supply plan, with commodities and quantities to be procured by each funder, is expected to be finalized before June 2021.

PEPFAR continues to engage with GF and GoK in planning for procurement of commodities to ensure that the commodity budget is fully funded. During the COP21 planning process, PEPFAR Kenya engaged GF and GOK to put in place a tripartite agreement on share purchases, with the GOK committing to an increasing share of commodities over time. Building on transitions in the procurement of commodities from FY20 and FY21, GOK will fully fund certain essential HIV commodities, such as co-

trimoxazole (both tablets and suspension), while also increasing its budget share for rapid test kits, CD4 reagents, other monitoring tests for patient managements, medicines and lab reagents for opportunistic infections, and condoms. Furthermore, there remains a need for increased GOK contribution toward the procurement of ARVs which stands at 9.8% for FY22.

PEPFAR Kenya's funding and procurement of commodities will continue to closely align to strategies adopted by different program areas. For prevention, in alignment with the strategy for efficient testing, procurement of rapid test kits will remain significantly low, while procurement of HIV self-test kits and recency kits will be increased to support case-finding.

Adult and pediatric optimization processes are on track and COP21 procurement of commodities will further support these initiatives. There are no planned procurements of NVP, NVP-based, efavirenz, and efavirenz-based regimens including tenofovir/ lamivudine/efavirenz (TLE). TLD has been prioritized to ensure that there are no funding gaps and all quantities required for the > 1 million patients on the regimen are available so patients can be transitioned to MMD as per the national guidelines. Only TLD will be procured in FY22 in line with the revised recommendations where TLD is the preferred first line regimen for all population groups including children weighing >35kg, adolescent girls, and women of reproductive age. Moreover, procurements of TLD will be limited to the 90-count bottles to support scale-up of DSD through multi-month prescriptions and MMD for all patients. For pediatric patients, only optimal formulations will be prioritized in the country's FY22 procurement plans. PEPFAR will specifically prioritize the procurement of pediatric formulations of dolutegravir (DTG 10 and DTG 50) to ensure rapid transition of children to more optimal, DTG-containing regimens in line with the revised WHO guidelines which recommend the use DTG for all children aged > 4 weeks and weighing > 3 kg. There will be no procurement of non-optimal/legacy pediatric formulations such as nevirapine, efavirenz and lopinavir/ritonavir

COP21 funding for EID and VL monitoring has been computed based on the WHO monitoring algorithms. PEPFAR funding contribution for COP21 is at 75% and 60% of the total needs for VL and EID respectively. Continued advocacy with the Ministry of Health and GF is required to ensure commodity availability to meet the country needs. PEPFAR Kenya is also closely working with the global pharmaceutical and non-pharmaceutical supply chain to minimize supply interruptions that have resulted from the COVID-19 pandemic and are impacting on phased and timely availability of commodities.

In addition, PEPFAR will continue working with GOK and other stakeholders to support efforts toward modernizing and entrenching a client-centered supply chain to maximize product availability, quality, affordability, and convenience to reach out to men and to meet the unique needs of different clients. This will also include exploring options for efficiently and effectively reaching patients on treatment through tailored channels appropriate to their needs and preferences such as community ART distribution or utilization of other

convenient locations for medicine pickup (e.g. private pharmacies) to strengthen adherence and continuity of treatment. This approach would also decongest public health facilities allowing more focused, individualized, and quality care to be provided by health care workers to non-stable patients who will continue to receive care at these centers. Moreover, PEPFAR, together with NASCOP and county governments, will continue to strengthen the supply chain by building capacity for commodity management and commodity security across all levels, as well as ensuring accountability through proactively monitoring and mitigating procurement and supply chain-related risks. Other initiatives to be prioritized will be the utilization of private sector capabilities and infrastructure such as Third-Party Logistics (3PL) in improving efficiency in the last mile delivery of commodities.

4.7 Collaboration, Integration, and Monitoring

PEPFAR Kenya will work with the Ministry of Health, UN agencies, and CSOs to enhance efficiency and cost-effective case finding interventions that will be implemented within human-centered approaches. Engagement will be through the national HTS technical working groups to enable collaboration with stakeholders to review HTS policy guidelines and revise to align with WHO 2019 guidelines.

In the context of the HTS 2015 policy guideline review process, PEPFAR Kenya will collaborate with stakeholders to review the HTS eligibility criteria for all sub-populations to reduce over-testing and improve yield as well as ensure safety and adverse event monitoring and reporting within index testing services. PEPFAR Kenya will also, in collaboration with the Ministry of Health, work towards a phased activation process of the public health approach in case finding. This phased activation will be focused on county categorization beginning with high burden counties scaling up to medium and low burden counties. PEPFAR Kenya will involve the Ministry of Health in its activities and strengthen collaborative site visits and mentorship activities including performance reviews at county level.

PEPFAR Kenya will continue to work with and strengthen county teams and monitor IP performance closely through SIMS and quarterly reviews with performance improvement plans done for poorly performing partners to ensure that they achieve their COP21 targets.

TWGs in each program area will include the county Ministry of Health in order to bring about synergy and improve efficiency. Facility and targeted community outreach strategies will be used to identify individuals living with HIV among KP and other targeted groups (children aged <15 years, youth, and men aged >25 years) through high yield HTS modalities, such as partner notification services and index client testing populations. Strict multisectoral safety and adverse event monitoring and reporting systems will be put in place.

To increase linkage to treatment to 95%, PEPFAR will support client escorts, the use of telephone and short text message reminders, and in-person follow-up by peer educators.

Further, PEPFAR will actively engage KP, vulnerable populations, local communities, and other stakeholders to address stigma and discrimination, harmful gender norms, and other barriers to accessing HIV care and services, including PrEP for which GOK has established guidelines targeting KP and vulnerable populations. In addition, PEPFAR will routinely forecast site-specific commodity needs and work closely with Kenya Medical Supplies Authority (KEMSA) to ensure service delivery points (SDPs) receive uninterrupted supplies, e.g. rapid test kits, condoms, lubricants, and methadone.

In scale up counties, PEPFAR will support intensified demand creation, targeted HTS, linkage to treatment, provision of PrEP for all eligible most-at-risk individuals including discordant couples, post-exposure prophylaxis (PEP), and VMMC. Innovative approaches will include enhanced monitoring for better tracking and continuity of treatment, implementation of PHDP, creation of PLHIV peer networks, convenient clinic working hours, and public health personnel sensitized to KP friendly service provision. PEPFAR Kenya will work with the Ministry of Health, UN, and CSOs to enhance and improve outcomes of C/ALHIV. Through the pediatric and adolescent TWGs, PEPFAR will work with all stakeholders to review pediatric ART policy guidelines and revise to align with WHO 2018 guidelines.

COP21 will support review of the HTS eligibility criteria for children and adolescents to reduce over-testing and improve yield for these vulnerable populations. In collaboration with the Ministry of Health and CSOs, COP21 will support universal testing of all children of PLHIV newly diagnosed or existing in care. Further, PEPFAR Kenya will work with the Ministry of Health to implement family-centered PAMA care for child-caregiver pairs in care to ensure a standard package to guide implementation, standard operating procedures (SOPs), and tools to track performance.

In COP21, PEPFAR will continue to intensify partner performance monitoring by conducting SURGE/LEAP visits in addition to SIMS. IPs with poor performance across key indicators will be put on a performance improvement plan, with intensified bi-weekly monitoring. Joint quarterly review meetings will be supported, with the objective of cross-learning, showcasing what's working and what's not working, and identifying what should be taken to scale. Review meetings will also help in identifying strengths, barriers, and areas for improvement, and come up with corrective action plans with clear roles, responsibilities, and timelines. Partners will have revised work plans to ensure issues identified are addressed.

4.8 Targets by Population

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY21)	Additional patients required for 80% ART coverage	Target current on ART (APR FY22) *TX_CURR*	Newly initiated (APR FY22) *TX_NEW*	ART Coverage (APR 22)
Attained	-	-	-	-	-	-
Scale-Up Saturation	776,599	724,124	(64,699)	766,476	58,340	99%
Scale-Up Aggressive	475,102	401,810	3,207	424,504	31,522	89%
Sustained	217,914	145,887	43,815	158,574	16,018	73%
Central Support	14,733	-	11,786	-	-	-
Commodities (if not included in previous categories)	-	-	-	-	-	-
TOTAL	**1,484,348**	**1,271,821**	**(5,891)**	**1,349,554**	**105,880**	**91%**

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Counties

SNU	Target Populations	2021 Population Size Estimate	Current Coverage -2019	*VMMC_CIRC* (in FY21)	Expected Coverage (in FY21)
Turkana	Men 15-64 years	271,938	69.2%	13,200	73.0%
Kisumu	Men 15-64 years	329,841	57.7%	12,500	60.1%
Siaya	Men 15-64 years	251,389	61.0%	8,250	62.7%
Homabay	Men 15-64 years	279,871	65.9%	8,200	67.3%
Migori	Men 15-64 years	280,177	66.9%	6,000	67.3%
Nandi	Men 15-64 years	257,090	91.7%	3,000	90.7%*
Nairobi	Men 15-64 years	1,448,254	88.0%	3,000	85.8%*
Military	Men 15-64 years	N/A	N/A	850	**N/A**
			TOTAL	**55,000**	

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (SNUs) and disease burden	Disease Burden	Coverage Goal (in FY21)	FY22 Target
FSWs	143,471 (excluding <18 years) 167,940 (all)	29%	95%	136,297
MSM	84,277	18%	95%	80,063
PWID	1,721 (Kisumu and Kiambu only)	18.6%	95%	1,635
Fisher Folk	Unknown	33.3%		123,065
Military	Undisclosed			61,776
People in Prison and other enclosed settings	Unknown			64,800
AGYW (9-24 years)	836,581 (AGYW at risk in 7 DREAMS SNUs)	2.4%	90% (cumulative)	321,241
			TOTAL	**788,877**

Table 4.8.4 Targets for Orphans and Vulnerable Children (OVC) and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children		Target # of OVC (FY22 Target)	Target # of OVC (FY22 Target)	Target # of OVC (FY22 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target)
County	Total Orphans due to AIDS	All Orphans	OVC_SERV Comprehensive	OVC_SERV Preventative	OVC_SERV DREAMS	OVC_HIVSTAT
_Military Kenya			193	0	0	190
Nairobi	17,246	99,256	75,082	12,303	49,290	73,718
Kisumu	35,887	77,408	55,014	9,765	16,448	54,012
Homa Bay	41,397	84,287	52,566	9,414	24,483	51,610
Kilifi	26,765	80,997	23,791	3,898	0	23,358
Siaya	30,440	68,971	20,114	4,046	13,730	19,746
Migori	29,606	85,443	19,082	3,727	33,072	18,736
Nakuru	36,135	86,118	18,866	3,092	0	18,522
Busia	13,301	45,573	15,755	2,581	0	15,468
Kiambu	18,568	71,525	14,813	2,428	20,150	14,544
Kakamega	19,361	91,362	14,445	3,367	0	14,180
Kisii	17,553	87,989	11,691	1,916	0	11,478
Bungoma	15,739	86,103	9,189	1,505	0	9,022
Kericho	16,661	41,132	8,214	1,746	0	8,062
Mombasa	21,951	47,247	8,136	1,333	20,798	7,988
Uasin Gishu	23,705	46,022	8,093	1,326	0	7,944
Turkana	15,560	40,804	6,704	1,098	0	6,582
Trans-Nzoia	19,579	44,794	5,719	937	0	5,614
Machakos	15,873	48,685	4,949	811	0	4,860
Kajiado	17,736	44,325	4,930	808	0	4,844
Meru	16,143	53,929	4,767	781	0	4,680

Makueni	12,191	37,737	3,830	628	0	3,756
Kitui	16,185	46,244	3,297	540	0	3,238
Muranga	8,431	33,591	3,287	538	0	3,228
Vihiga	6,561	27,620	2,708	444	0	2,660
Nyamira	7,239	41,073	1,631	267	0	1,604
Kwale	15,197	48,759	0	0	0	0
Lamu	1,982	7,097	0	0	0	0
Taita-Taveta	5,021	15,107	0	0	0	0
Tana River	4,255	19,192	0	0	0	0
Garissa	2,736	29,367	0	0	0	0
Mandera	3,158	35,006	0	0	0	0
Wajir	2,699	29,936	0	0	0	0
Embu	5,657	19,969	0	0	0	0
Marsabit	4,187	18,702	0	0	0	0
Isiolo	2,654	10,367	0	0	0	0
Tharaka-Nithi	4,056	13,447	0	0	0	0
Nyeri	6,586	21,752	0	0	0	0
Nyandarua	5,854	23,537	0	0	0	0
Kirinyaga	4,591	17,217	0	0	0	0
West Pokot	8,868	31,540	0	0	0	0
Narok	20,803	56,498	0	0	0	0
Nandi	14,539	38,266	0	0	0	0
Elgeyo-Marakwet	6,693	20,310	0	0	0	0
Laikipia	7,320	20,769	0	0	0	0
Bomet	15,686	42,592	0	0	0	0
Baringo	9,770	31,169	0	0	0	0
Samburu	4,191	15,217	0	0	0	0
TOTAL	**656,318**	**2,084,050**	**396,866**	**69,300**	**177,971**	**389,644**

Table 4.8.5. Recruitment Plan for C/ALHIV Aged <18 Years by SNU

County	ART Coverage (FY21 TXCURR Results / COP21 Estimates	COP21 OVC County	COP20 TX_CURR <18 Years Target	CALHIV Enrolled in the OVC Program (COP19)	90% Expected CALHIV Enrolment by COP20	95% Expected CALHIV Enrolment by COP21
_Military Kenya		Yes	225	207	203	214
Bungoma	High	Yes	2,703	1,762	2,433	2,568
Busia	High	Yes	2,663	2,166	2,397	2,530
Homa Bay	High	Yes	11,714	8,771	10,543	11,128
Kajiado	Low	Yes	1,486	997	1,337	1,412
Kakamega	High	Yes	4,550	3,772	4,095	4,323
Kiambu	High	Yes	3,136	1,291	2,822	2,979
Kilifi	Medium	Yes	3,130	2,162	2,817	2,974
Kisii	Medium	Yes	3,119	2,232	2,807	2,963
Kisumu	High	Yes	10,045	7,374	9,041	9,543
Kitui	Medium	Yes	2,809	1,294	2,528	2,669
Machakos	Medium	Yes	2,678	1,806	2,410	2,544
Makueni	High	Yes	2,250	872	2,025	2,138
Meru	Medium	Yes	2,388	1,269	2,149	2,269
Migori	High	Yes	7,414	4,909	6,673	7,043
Mombasa	High	Yes	2,900	2,225	2,610	2,755
Muranga	High	Yes	1,394	644	1,255	1,324
Nairobi	High	Yes	10,091	6,580	9,082	9,586
Nakuru	Medium	Yes	3,791	1,810	3,412	3,601
Siaya	High	Yes	9,350	6,813	8,415	8,883
Trans-Nzoia	Low	Yes	1,914	1,121	1,723	1,818
Turkana	Low	Yes	2,044	742	1,840	1,942
Uasin Gishu	Low	Yes	2,796	1,021	2,516	2,656
Kericho	Medium	Yes	1,660	1,140	1,494	1,577
Nyamira	High	Yes	1,425	885	1,283	1,354
Vihiga	High	Yes	1,904	1,315	1,714	1,809
Baringo	Low	No	547	306	492	520
Bomet	Low	No	1,209	647	1,088	1,149
Embu	High	No	955	486	860	907
Kirinyaga	High	No	697	-	627	662
Kwale	Low	No	1,736	866	1,562	1,649
Laikipia	Medium	No	880	106	792	836
Nandi	Low	No	1,385	582	1,247	1,316
Narok	Low	No	1,561	566	1,405	1,483
Nyandarua	High	No	1,016	402	914	965
Nyeri	High	No	1,311	564	1,180	1,245
Taita Taveta	Medium	No	610	340	549	580

Tharaka Nithi	High	No	677	342	609	643
West Pokot	Medium	No	353	232	318	335
Elgeyo-Marakwet	Low	No	427	260	384	406
Samburu	Low	No	304	19	274	289
Garissa	Central Support	No				
Isiolo	Central Support	No				
Lamu	Central Support	No				
Mandera	Central Support	No				
Marsabit	Central Support	No				
Tana River	Central Support	No				
Wajir	Central Support	No				
TOTAL	-	-	**113,247**	**70,898**	**101,925**	**107,587**

Reference:

COP21 ART Coverage Thresh hold

> = 80% is High
70 -79% is Medium
< 70% is Low

4.9 Cervical Cancer Program Plans

Despite the challenges faced during the COVID-19 pandemic, Kenya has scaled up cervical cancer screening and treatment across all supported sites. This support will continue in COP21. Despite the progress, a major gap has been noted in access to treatment for those who are positive. This is due to the limited number of treatment equipment in supported facilities. As a vast majority of the screening services are being offered in MCH clinics, PEPFAR Kenya will continue strengthening the linkage between HIV clinics and MCH clinics for women referred for screening. Facilities will coordinate screening with MMD appointments so that all women are reached conveniently. COP21 will also strengthen demand creation at site level through use of IEC, health talks, and use of peers and support physical escort of women from HIV clinics to MCH for screening and treatment and prioritize their screening to avoid waiting. In addition, peers will remind clients of screening dates. PEPFAR Kenya is working with NIH to develop a reminder and referral system to track women referred for treatment.

For COP21, PEPFAR Kenya will analyze facility performance, identify bottlenecks, and offer support to sites not achieving their screening targets. PEPFAR funds will continue to support screening by visual inspection of the cervix with acetic acid (VIA), as well as support the Ministry of Health to scale up HPV screening. For COP21, cervical cancer has been allocated an additional $1,000,000 from COP20 funding to $3,000,000. These funds will be used to strengthen testing and treatment at facility level.

To align with WHO's 90-70-90 cervical cancer elimination targets, PEPFAR Kenya will work with the Ministry of Health, county governments, and other partners to improve access to treatment services in all supported counties. Women with suspected cancer will be supported to access treatment at the nearest sites that have cervical cancer treatment capacity. PEPFAR Kenya will work with the National Cancer Control Program (NCCP) to develop a referral directory for ease of referral. PEPFAR Kenya will track referrals through phone calls and SMS, then coordinate with referral sites to ensure linkage and timely access to treatment services.

In COP21, priorities at site level will be:

- Ensure cervical cancer screening for all HIV positive women aged 25-49 years
- Map facilities with cryotherapy, thermocoagulation, and LEEP equipment and develop referral mechanisms from lower-level facilities
- Ensure all screening sites have access to treatment services either onsite or through prompt referral per the Test and Treat approach
- Strengthen county-level histopathological laboratory investigation capabilities
- Support procurement of laboratory commodities for VIA screening
- Develop MPR for QA at screening and treatment sites
- Support health worker training and mentorship for cervical cancer screening and treatment
- Support county-level mentorship teams to mentor facilities on a regular basis and link to a county-level HIV TWG to improve screening QA with mentorship and QA integrated across respective health program areas.
- Develop a county-level consultation mechanism for facility providers

Additionally, COP21 will work to improve cervical cancer reporting at facility level though printing, development, and distribution of cervical cancer registers and reporting tools (including referral forms and summary tools). It will also support facilities in monthly monitoring and reporting of cervical cancer performance, as well as screened positive rates, treatment rates, and time to referral/treatment for those screened positive.

PEPFAR Kenya will monitor key quality indicators assessing structures, processes, cervical cancer screening outcomes, and treatment outcomes. PEPFAR Kenya will evaluate some indicators, including screening positivity rates, time from screening to treatment, and post-treatment follow up rates. Facilities offering cervical cancer screening and treatment will seek regular client feedback to ensure the provision of client-centered screening and treatment services. The program will institutionalize CQI for continuous improvement. PEPFAR Kenya will also establish a system of adverse event monitoring for treatment services.

For women with advanced cervical cancer, COP21 will support linkages to palliative care services for women with advanced cervical cancer. VIA will be supported as the primary

screening modality. There are some sites piloting HPV screening and, in these sites, the HPV screening algorithm will be used.

At above site level, PEPFAR Kenya will support:

- Procurement of some thermoablation devices for treatment of cervical dysplasia.
- National level reporting through DHIS-2
- Regional cancer registries to improve population-level Cervical cancer monitoring
- The National Oncology Reference Laboratory (NORL) to strengthen QA by providing mentorship to Level 5 and 6 facilities on histopathologic investigations
- Integration of cervical cancer screening and treatment into Kenya EMR
- NCCP for supervision and guideline development and implementation
- Optimal and quality reporting through both DATIM and DHIS-2

4.10 Viral Load and Early Infant Diagnosis Optimization

In COP21, priorities will be targeted toward continued optimization of the existing 10 conventional testing systems and an increased focus on the 6 point-of-care (POC) systems geared toward efficiencies and strategic placements. These will include mapping out existing/active POC sites for both EID and VL, determining the capacity of existing sites, and monitoring POC utilization and needs.

Through lab-clinical interfaces, sites with high numbers of PBFW that will benefit from POC placement vis-a-vis conventional testing systems and available infrastructure will be prioritized for POC placement, if additional resources are available. COP21 will strengthen integration and optimization of sample referral networks for both conventional testing systems and POCs to improve access and efficiency for VL/EID and the re-mapping and integration of sample referral networks.

LARC-like CQI initiatives that track patients, their specimens, and the return of results to caregivers will be implemented to strengthen the lab-clinical interface. Counties and facilities with long turnaround time for EID and VL will be mapped and barriers to timely return of results mitigated. Use of data systems to include SMS to alert patients of the availability of their test results will be expanded within the national diagnostic network optimization (DNO). In COP20, COVID-19 posed challenges to patient availability for sample collection, efficiency of the laboratory networks, and laboratory testing leading to decreased VL coverage and long turnaround times. The root causes for this are currently being addressed and efficiencies will be explored to ensure 100% VL coverage in COP21.

Currently, there are 67 potential POCs dedicated to VL and EID that are underutilized or frequently stocked out. In COP19, only 0.5% of all VL tests and 14% of EID tests were performed at POCs, while at end of FY20 only 1% of VL and 5% of EID tests were recorded on these platforms. In the lab optimization activities of COP21, PEPFAR Kenya will continue working with other stakeholders to increase efficiencies in equipment placement and utilization. Whereas PEPFAR has invested heavily in the conventional systems, collaboration with Ministry of Health, GF, and other funders on activating the already existing POCs beyond the 6 PEPFAR-supported sites will take place through technical assistance and quality management systems. This process will work toward adding value and sustainability as PEPFAR Kenya transitions to domestic financing. Any gaps identified on VL/IED networks will be addressed through the national VL TWG while ensuring efficiencies are attained towards increasing access on the conventional systems.

4.11 Program Adaptations during COVID-19

The COVID-19 pandemic required a number of PEPFAR Kenya program adaptations during COP20 which will continue into COP21. These include:

- Provision of personal protective equipment (PPE), hand washing stations, and hand sanitizers within ART clinics to protect clients and health care workers against COVID-19
- Multi-month ART dispensing (3-MMD, preferably 6-MMD) to reduce trips to health facilities
- Flexible ART appointment schedules and delivery models to decongest ART clinics, including extended clinic hours
- Evaluation of suspected COVID-19 patients for TB and vice versa
- Virtual support to patients including virtual counseling, psychosocial care, and video directly observed therapy (VDOT)
- Community ART initiation
- Use of courier by some partners to deliver ARVs to patients unable to travel to ART clinics for drug pickups
- Expansion of community DSD models including community ART pick-up points.
- Activation of infection prevention and control (IPC) committees
- Enhanced IPC measures and adherence to Ministry of Health guidelines including masking, distancing and hand hygiene

- Improvement of facility infrastructure and patient flows to ensure decongestion (e.g. modified triage with fast tracking of respiratory and febrile patients; improved ventilation and screens to protect health care workers)
- Health care worker and general population vaccination with priority to the vulnerable
- Leveraging other COVID-19 response resources from GOK and USG through CARES funding and the American Rescue Plan, as well as from other donors in a multisectoral approach

To combat the spread of COVID-19, GOK has introduced lockdown measures, movement restrictions, and curfews. This has affected service delivery at both community and facility level since service providers cannot move freely. To address this, COP21 will ensure that all community service delivery agents receive passes to be able to continue providing community-level and outreach services past curfew hours. COP21 will also support all community health workers and community organizations to receive PPE in order to continue providing direct support to PLHIV and KP at community level. PEPFAR Kenya will also revive support groups at all PEPFAR-supported sites and encourage innovation to ensure that PLHIV and KP continue to be supported even during the COVID-19 pandemic restrictions.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

In order to strengthen health systems in Kenya to achieve and sustain epidemic control, COP21 has prioritized systems-level investments based on gaps identified through various tools including progress made from SID 3.0 to SID 4.0 and the Responsibility Matrix (RM), quarterly POART/MER results, and SIMS using a consultative process with the Ministry of Health, CHMTs, the GF prime recipients, and CSOs and FBOs. During COP21 development, there was also extensive stakeholder engagement and consultation with the Ministry of Health, the National Treasury, county governments, GF, the Bill & Melinda Gates Foundation and other donors, as well as the private sector and UNJT.

Unlike previous years, where PEPFAR support was complementary to already available support for critical areas such as policy and governance, institutional capacity building, and harmonization of different information systems, this year the GOK and its development partners will build upon PEPFAR's resource commitments. More responsibilities with respect to systems support—including for commodities—are being transitioned to Ministry of Health at national and county levels to improve sustainability.

PEPFAR Kenya has reviewed progress made based on COP20 Table 6 areas to identify which areas are 'on' or 'not on' course to achieve intended outcomes and which activities

are no longer relevant. Table 6 activities that require further investment to achieve and sustain elimination are included in COP21 Table 6 and linked to respective program areas. Activities related to systems support for transition and sustainability that are not in COP20 Table 6, but that are relevant to ensuring fidelity, have also been included.

As described in SDS section 2.4, SID domains scoring yellow (4.67-6.67: emerging sustainability) and requiring some investments are prioritized in COP19 Table 6 (including commodity security and supply chain (5.18), private sector engagement (5.71), epidemiological and health data (6.0), laboratory service (6.11), service delivery (6.33), and HRH (6.43). The SID elements of quality management (9.05), policy and governance (7.19), and domestic resource mobilization (7.18) appear to be sustained but still require ongoing investment based on the evolution toward UHC and the need for effective capacity for a devolved health system.

The following areas have been identified as requiring particular program support toward achieving and sustaining epidemic control:

5.1 Guidelines on Emerging Evidence

Program support is required to ensure a review of policies and technical area guidelines based on emerging evidence (e.g. revised HTC algorithms based on current HIV prevalence, emphasis on PLHIV continuity of treatment through individual tracking and unique identifiers, new TB preventive therapy, and multi-dose scripting/MDD, etc.).

5.2 County Systems Strengthening

Key program strategic objectives for county systems strengthening include: 1) increasing sustainable finance and domestic resource mobilization for the health sector; 2) improving the quality of training and increasing the number of those graduating and entering the workforce; 3) improving governance, management and leadership of the health workforce at the county level and strengthening technical leadership; 4) improving county- and community-level systems for enhanced access to quality care, partnerships and private sector engagements, and coordination for commodity management.

5.3 HRH

It is essential to support systems for HRH management to enhance performance and productivity at all levels of service delivery, as well as functionality of the HRH units in counties where PEPFAR Kenya supports health services. Support for HRH should ensure a rationalized and right-sized workforce that is efficiently utilized for HIV services at community and facility levels. Functional county HRH units have been effective in enabling county governments to prepare strategic plans and budgets to mobilize resources. Coordination of county and intercounty cluster fora will be supported to ensure that deeper engagement of counties and learning and adaptation of success in HIV management takes place. The PEPFAR-supported HRH data system will be used to guide decisions and budgets for a rationalized and right-sized workforce based on epidemic control needs. Workforce unrest and labor disputes have made it necessary to support regular

engagements between the Ministry of Health, Council of Governors, CHMTs, and health worker leadership for closer and continuous dialogue to minimize disruptions in PLHIV service delivery and target achievement and sustainability for epidemic control.

Workplace environment improvements, as well as interventions to enhance quality of care by health workers, is an area of focus during in COP21, especially in the wake of COVID19 and concerns for health workers safety. Community-level workforce systems will be supported to enhance their productivity, alignment to public service requirements and ownership by counties leading to eventual absorption. County readiness assessments will be supported, and the findings used to identify HRH game changers that, when supported, will contribute to county maturity toward self-reliance and sustainable transition of investments. At the county and site level, it has been identified in COP19 that loss to follow-up is a major impediment to retaining those identified in care. As a result, IPs will be required to ensure there are health workers hired and supported to actively trace and bring back to care those experiencing interruption in treatment through community-level engagements and home visits among other innovative approaches.

5.4 Commodity Management

Strengthening technical leadership and coordination for sustainable commodity management at both the national and county levels will involve reinforcing commodity security TWGs, mainstreaming laboratory and nutrition commodities into one coordinated national supply chain system for all HIV commodities, in-service and pre-service curriculum development for supply chain management, and support for quantification and supply planning at national level.

5.5 Health Financing

Health financing approaches will include advocacy for increased allocations to health and HIV in the national budget, technical assistance in 7 counties to institutionalize county health planning and budgeting, and support for evidence generation to inform domestic resource mobilization including monitoring domestic resource mobilization trends. COP21 will also support private sector engagements to facilitate access to affordable HIV/AIDS services in the private sector and reduce the financial and operational burden on the public health facilities, as well improve access to affordable HIV care and treatment services through private sector care, and technical assistance to inform NHIF reforms and related sustainable financing for HIV as part of GOK's UHC agenda.

5.6 Laboratory

Kenya has made substantial progress in optimizing diagnostic networks for VL and EID. COP21 activities will prioritize enhanced access to VL and EID testing services and timely return of results to support eMTCT and efficient follow-up of non-virally suppressed PLHIV for effective management. Maintenance of quality laboratory management systems (QMS) for national referral labs' VL/EID, TB, HIV-DRT and BSL3 labs will remain a priority activity to assure reliable, accurate, and timely VL/EID/TB/HIV DR results. The QMS package will

incorporate internal quality assessment (IQA) and EQA for VL, EID and DR alongside covering all non-conventional (POC) sites.

In continuing to build on the integrated specimen referral system, PEPFAR will support the expansion to include DR testing. This integrated approach will enhance the progress already made in COP19 and COP20.

As per the Ministry of Health strategy, PEPFAR Kenya will continue to provide technical assistance toward the transitioning of VL/EID testing laboratories to the Ministry of Health-owned regional laboratories. Close monitoring of this process will ensure that the already high VL coverage and equipment (VL/EID, TB) optimization are not negatively impacted. In the process, gaps in effective and efficient identification of POC sites against conventional platforms will be addressed through the national VL TWG.

The national equipment calibration center will continue ensuring that the national and regional referral network hubs have calibrated pipettes, centrifuges, fridges, and freezers to optimize transition of dried blood spot (DBS) to plasma for increased accuracy in VL measurements to ultimately realize the goal of Undetectable = Untransmittable (U=U).

In an effort to ensure the quality of HIV/TB-related testing, PEPFAR will continue to support the integrated external quality assessment (EQA) for HIV/TB diagnostics including for GeneXpert Ultra, TB LAM, RHT, VL and EID. The National Public Health Laboratory (NPHL) will be supported to coordinate Rapid Test Continuous Quality Improvement (RTCQI) activities including the creation of a national certification system for sites and testing personnel involved in rapid HIV testing. A national HIV recency testing QA program will be conducted under the framework of the HIV recency surveillance in Kenya. To foster sustainability of lab quality services for reliable results, technical assistance will be provided to the national lab diagnostic unit to coordinate national laboratory assessments and monitoring of Stepwise Laboratory Improvement Process Toward Accreditation (SLIPTA) implementation, ensuring harmony across stakeholders (e.g. World Bank, Ministry of Health, and the private sector).

PEPFAR Kenya will provide technical assistance toward establishing a national GTC waste management system for waste emanating from Roche VL/EID and GeneXpert cartridges. This will include mapping of incinerators with required capacity (>1000°C incinerators)—e.g. cement manufacturers—and development of a national Guanidinium thiocyanate (GTC) waste disposal network.

5.7 Strategic Information

As all PEPFAR Kenya-supported counties will be expected to implement key surveillance activities such as case-based surveillance, recency testing for all newly diagnosed positives, and mortality surveillance, the health information system (HIS) is foundational to the ability to survey and monitor the epidemic and inform prompt program response for the achievement and sustainability of epidemic control. COP21 support involves the

development of scalable, flexible, and context-appropriate HIS processes to facilitate client-centered services, program monitoring and reporting, and HIV disease surveillance informing public health strategies to achieve and sustain HIV epidemic control in Kenya.

COP21 will continue to support strategic information initiatives in all PEPFAR-supported counties so counties can generate and use high quality individual-level data to drive impact and move toward full ownership for sustainability. All county typologies will be supported to conduct continuous DQA and improvement initiatives strengthening timely, correct, and consistent reporting to the Ministry of Health through the DHIS-2 and PEPFAR DATIM systems in order to move toward data alignment and sustainability of information systems. For the county-level checks across multiple HIS systems, PEPFAR Kenya will work with the M&E COE led by NASCOP to identify priority areas and plan for action.

As Kenya moves toward a full public health response model at both county and national levels, it is expected that all facilities with a large number of people in HIV care will adopt and consistently use digitized health information systems. To promote flexibility in the developed systems and ownership of electronic medical records (EMR) by counties, COP21 will support the scaling and migration of all existing HIV EMRs to one open source digital health solution for the HIV sector, as guided by PEPFAR partnership with Ministry of Health under NASCOP direction. Work on unique patient identifiers (UPI) is ongoing and progress will be assessed by end of COP20.

Interoperability between HIS products will continue to be a priority to ensure that data fragmentation between siloed systems is reduced. Interoperability will allow for other HIS products and health-sector wide strategic information initiatives to build on PEPFAR Kenya's ongoing success with digital health solutions and enable the focus of PEPFAR's support on HIV/TB systems components. These HIS products include mobile health applications which play a pivotal role in meeting the dynamic and evolving program and data needs of the PEPFAR Kenya-supported HIV response, such as the need for early identification of non-virally suppressed patients, categorization of "stable patients," and timely detection of missed appointments. Other key systems include eHTS electronic HTS reporting and case-based surveillance.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

6.1 USAID

PEPFAR-Kenya is committed to epidemic control, moving swiftly toward a county-led model with indigenous partners assuming a greater role in direct service delivery, monitoring, supportive supervision, mentorship and technical assistance to maintain quality HIV service delivery. In COP21, communities through community-led monitoring

will provide further oversight to all HIV services provided by USAID. To this effect, USAID will in COP21 continue to embrace county and community input in program planning, implementation as well monitoring to foster a stronger partnership around HIV/TB and social, client-centered service delivery.

The broad footprint in COP21 takes into consideration having adequate staffing to effectively engage other bilateral partners and national, county, and community stakeholders in co-creation, implementation and monitoring of programs. This is reflected in the interagency staffing patterns and level of effort (LOE) by program area and administration support.

The PEPFAR interagency discussed emerging and vacant positions to determine relevance for each agency, as well as the entire country portfolio, given the dramatic shifts in COP19 and moving into COP21. As such, USAID had 28 new positions, some of which have already been competitively filled. The number (full time equivalents) of PEPFAR Kenya staff and percent of time allocated remain aligned to the interventions described herein and maintain coverage for SIMS, business processes, and interagency partner management. USAID understands that moving to local partners and taking a county approach to service delivery will require intensive partner monitoring, as well as some capacity building, as we cement partnership with country governments and development partners in each county. County-by-county programing, planning, and monitoring, while geared toward laying a stronger foundation for local ownership, also comes at a higher initial cost of creating, building, and nurturing partnerships. This will require more human resources investment.

USAID Kenya has made an attempt to fill most of the long-term vacant positions and is working diligently to fill the remaining ones, some of which are under the process of being posted. All agencies reviewed vacant positions and updated those position descriptions to facilitate the re-advertisement of the positions to both meet the needs of COP19 while moving into COP21. This includes agencies utilizing standardized job descriptions and other pre-classified position descriptions to expedite the placement and hiring of new staff. However, the biggest challenge in filling positions is the approval process timeline which often creates lengthy delays up to 12 - 15 months. USAID has repurposed some of its local hire positions to improve oversight of program and fiscal management of PEPFAR partners. Most of these positions have undergone classification and received final U.S. Embassy Human Resources (HR) approval for advertisement.

Costs of doing business (CODB) is increasing slightly for USAID in COP21 due to: 1) a 5% increase from COP19 for internationally-recruited staff to cover for the staff salary and step increases during FY 20; 2) a 6% increase from COP19 for locally-recruited staff to cover the staff salary and step increases implemented in FY 20. There is also an inflation driven increase for capital security cost sharing: computers, IT services, ICASS, management meetings, professional development, and non-ICASS.

USAID is in the process of closing out most of its international mechanisms and transitioning to local IPs after a rigorous period of solicitations seeking local and indigenous partners. By the beginning of COP21, USAID should have over 70% of its funding flowing through local partners. With a significant increase in PEPFAR Kenya resources being provided directly to local entities, USAID/Kenya also must provide greater accountability for USG resources through fiduciary monitoring.

Additional oversight is required to manage the significant challenges of the Kenya context regarding corruption and fraud both within and outside of the public sector. A more labor-intensive approach is also required for increased oversight and management of USAID Kenya contractors and grantees to ensure that programs operate more efficiently and cost-effectively and that they meet PEPFAR targets efficiently and effectively. A critical component of this approach is more frequent monitoring, reporting, and analyzing of results to make course adjustments and adapt program approaches. USAID Kenya has also been unable to fulfill its SIMS requirements, which significantly increase the demand for USG staff time dedicated to partner monitoring. In the context of the COVID 19 pandemic, USAID has adapted to intensified virtual TA and program monitoring. The additional staff will provide USAID support for a robust and intensive monitoring plan for the local IP's in order to get the program right and achieve the targets in COP20 and 21.

By the beginning of COP21, USAID will have finalized hiring new positions approved in COP19 to support local partner transition. There will be no new positions in COP21. An increase in USAID staff dedicated to PEPFAR will also bring USAID into balance with other PEPFAR implementing agencies in Kenya. The USAID Kenya business model also is changing to one of more direct staff engagement in managing development relationships with local governments and counties. In COP21, USAID (through OVC, DREAMS, MNCH, and malaria) will work in about 34 of the 40 PEPFAR counties including 23 where they are the lead agency with HIV service delivery. This direct engagement with the GOK is aimed at strengthening and building the capacity of public institutions and building partnerships to leverage resources.

By the end of COP 20, USAID will have all the 12 local implementing partners awarded and most of the 28 positions proposed in COP19 which include 16 public health specialists positions that will serve in partner management roles hired, to focus on monitoring and supportive supervision of the local partners and local governments, particularly county governments. The additional staffing will lead administration, finance, and operational support activities along with partner management and will spend approximately 40% of their time monitoring activities in the field. USAID's vision is to increase in-house USAID staff capacity to reduce reliance on international partner staff as we transition to local partners. This will also enable USAID to make more effective use of U.S. taxpayer resources, as USAID will no longer have to pay international partners' overhead rates for "indirect costs."

6.2 CDC

CDC Kenya has decreased its staffing by 1 full-time equivalent (FTE) from COP19 to COP21. The position is administrative. CDC has a total of 14 FTE vacancies and intend to hire the majority of positions by the beginning of COP20. CDC is not requesting any new positions and intends to conduct a staffing review and ensure existing positions align to support county activities and readiness toward direct county government-to-government funding through CDC Cooperative Agreements as well as through enhanced site level technical assistance. As such, CDC CODB remains similar to COP19 with anticipated increases in salaries and rent.

The CDC Kenya program has a robust history of funding local partners. CDC is on track to move from 62% of its program funding allocated to local partners in COP19 to 70% in COP20. CDC Kenya has plans to increase its funding to local partners to above 70% in COP21 and beyond and is exploring procurement options for county government-to-government cooperative agreements in COP20.

6.3 Peace Corps

As Peace Corps is reopening its program in Kenya and will have a small group of volunteers in late-2021 – early-22 (building to approximately 100), it has requested the hiring of a locally-employed staff (LES) Partnerships Manager via a Peace Corps personal services contract (PSC) mechanism. The incumbent will coordinate PEPFAR programming, monitoring, and reporting in Kenya, and coordinate the training of additional appropriately-funded staff, trainees, volunteers, and Kenyan counterparts. These volunteers and their counterparts will be working in GOK health facilities, secondary schools, and CBOs or FBOs. The Partnerships Manager will ensure that training and programming funded by PEPFAR will be appropriately designed and implemented according to O/GAC guidelines. Additionally, they will coordinate the collection of data and submission of sub-annual program reporting (SAPR) and annual program reporting (APR) and the Peace Corps Kenya submissions of various planning tools.

6.4 State

In COP21, PEPFAR State will be hiring a DREAMS Coordinator to provide additional support to the country team with the expansion of DREAMS programming to new geographical areas as per guidance in the planning level letter.

6.5 Department of Defense

The positions that have been filled since COP19, as well as those still under recruitment, have been prioritized to best match the program priorities and reflect the interagency analysis on new positions. Each position has been aligned according to staffing, management, and operations that exist in COP20 and are still applicable for COP21.

DOD continues to push recruitment actions for all vacant positions (currently 1 HIV specialist for Care and Treatment, 1 HIV Prevention specialist and 1 Health Management Information System specialist). All three positions have been advertised and are expected to be filled by FY21 Q4.

Each position is designed to balance business process coverage, intra-agency partner management, and the technical needs associated with program implementation. Depending on the role, staff will provide overall oversight to the SIMS. Those positions more focused on programmatic delivery will participate in SIMS assessments of DOD PEPFAR-supported facilities while providing technical assistance and guidance, interagency coordination, and communication. Working with the DOD PEPFAR team, each staff member will be tasked with focusing on the support and improvement of the provision of technical assistance and oversight of linkage, continuity of treatment, and client-centered services. In addition, identified staff will be tasked with providing technical assistance and oversight for the rapid roll out of small grants for community-led monitoring. The USG DOD PEPFAR team is structured to deliver current PEPFAR activities as well as those defined in the COP21 plan and to continue to match the program requirements as more elements of the program are transitioned to county government.

All new positions have been designed to improve program oversight and fiscal management of PEPFAR USG government-related functions. Each position requires leadership and management experience that extends beyond the capacity of the existing positions and hence requires new hires rather than repurposing an existing position. Only one position is to be filled by a US citizen. Over the next 5 years, the roles and responsibilities of this position will evolve to include both PEPFAR and non-PEPFAR activities.

DOD does not propose any major changes to the cost of doing business in COP21.

Table 6.5 DOD CODB Staffing Recruitment Summary Table

Position	Role	International/ LES	Recruitment Status	Reasons for delay
Director	Technical Leadership/Management	International	Recruited. Onboarding process ongoing	Lengthy agency approval process
Laboratory Director	Technical Leadership/Management	LES	Recruited, in position	
HIV Specialist, Care & Treatment	Technical and Programmatic Oversight and Support	LES	Recruitment in progress. Interviews scheduled for May 2021	Slow agency process in classification and approval
Health Management Information Systems Specialist	Technical and Programmatic Oversight and Support	LES	Recruitment in progress. Interviews scheduled for May 2021	Slow agency process in classification and approval
HIV Prevention Specialist	Technical and Programmatic Oversight and Support	LES	Recruitment in progress. Interviews	Slow agency process in classification and approval

			scheduled for May 2021	
Deputy Director	Technical and Programmatic Oversight and Support	LES	Recruited, in position	
TB Coordinator	Technical and Programmatic Oversight and Support	LES	Recruited, in position	

APPENDIX A -- PRIORITIZATION REQUIRED

Table A.1: Continuous Nature of SNU Prioritization to Reach Epidemic Control

County	COP	Prioritization	APR Results Projected	Treatment Coverage at APR by Age and Sex					
				<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Baringo	COP15	Sustained	3,001	57%			49%	74%	54%
Baringo	COP16	Sustained	3,167	57%	35%	32%	45%	72%	57%
Baringo	COP17	Sustained	3,222	58%	27%	19%	46%	77%	58%
Baringo	COP18	Sustained	3,855	75%	53%	53%	53%	83%	69%
Baringo	COP19	SCALE	5,172	107%	61%	85%	69%	74%	75%
Baringo	COP20	SCALE	4,594	134%	41%	40%	46%	59%	55%
Baringo	COP21	Sustained	4,893	61%	40%	41%	55%	62%	58%
Bomet	COP15	ScaleUp Agg	9,586	79%			75%	122%	86%
Bomet	COP16	ScaleUp Agg	11,088	93%	74%	69%	83%	122%	99%
Bomet	COP17	ScaleUp Sat	10,732	84%	62%	55%	91%	115%	96%
Bomet	COP18	ScaleUp Sat	13,073	95%	97%	97%	97%	142%	117%
Bomet	COP19	EVOLVE	11,774	91%	89%	126%	101%	98%	100%
Bomet	COP20	EVOLVE	10,439	139%	46%	54%	49%	74%	65%
Bomet	COP21	Sustained	11,035	70%	38%	48%	63%	79%	69%
Bungoma	COP15	ScaleUp Agg	21,327	84%			60%	95%	71%
Bungoma	COP16	ScaleUp Sat	22,178	82%	66%	72%	59%	82%	74%
Bungoma	COP17	ScaleUp Sat	22,485	82%	69%	69%	60%	84%	75%
Bungoma	COP18	ScaleUp Sat	26,931	101%	71%	87%	71%	100%	89%
Bungoma	COP19	EVOLVE	27,749	89%	63%	121%	96%	106%	100%
Bungoma	COP20	EVOLVE	25,791	102%	29%	111%	29%	209%	76%
Bungoma	COP21	Scale-up: Saturation	27,189	92%	46%	66%	71%	112%	92%
Busia	COP15	ScaleUp Sat	30,042	76%			75%	101%	78%
Busia	COP16	ScaleUp Sat	32,385	76%	63%	61%	76%	96%	84%

Busia	COP17	ScaleUp Sat	32,941	76%	53%	56%	78%	99%	85%
Busia	COP18	ScaleUp Sat	34,502	95%	72%	72%	77%	101%	90%
Busia	COP19	SCALE	36,213	79%	61%	94%	98%	101%	95%
Busia	COP20	SCALE	33,248	208%	61%	44%	90%	81%	83%
Busia	COP21	Scale-up: Aggressive	34,225	67%	38%	49%	83%	101%	86%
Elgeyo Marakwet	COP15	Sustained	2,419	54%			48%	78%	55%
Elgeyo Marakwet	COP16	Sustained	2,722	54%	25%	48%	50%	79%	62%
Elgeyo Marakwet	COP17	ScaleUp Sat	2,645	53%	26%	27%	48%	81%	60%
Elgeyo Marakwet	COP18	ScaleUp Sat	3,944	90%	76%	76%	76%	104%	90%
Elgeyo Marakwet	COP19	SCALE	4,194	81%	66%	94%	76%	71%	75%
Elgeyo Marakwet	COP20	SCALE	3,596	147%	30%	38%	38%	56%	50%
Elgeyo Marakwet	COP21	Sustained	4,873	95%	37%	45%	58%	76%	68%
Embu	COP15	Sustained	8,219	93%			90%	93%	74%
Embu	COP16	Sustained	7,948	91%	33%	21%	79%	84%	71%
Embu	COP17	Attained	8,040	90%	38%	19%	81%	85%	72%
Embu	COP18	Sustained	9,972	98%	75%	75%	87%	95%	90%
Embu	COP19	EVOLVE	9,948	84%	100%	153%	81%	86%	90%
Embu	COP20	EVOLVE	10,341	219%	160%	70%	84%	83%	87%
Embu	COP21	Scale-up: Saturation	10,549	122%	90%	78%	96%	99%	97%
Garissa	COP15	Sustained Com	1,087	17%			100%	53%	43%
Garissa	COP16	Sustained Com	1,158	13%	113%	94%	66%	31%	46%
Garissa	COP17	Sustained Com	1,223	16%	115%	100%	68%	33%	48%
Garissa	COP18	Sustained Com	1,333	50%	82%	68%	47%	48%	53%
Garissa	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Garissa	COP20	GOK/TRANSITION		61%	28%	43%	44%	58%	52%

Garissa	COP21	Centrally Supported							
Homabay	COP15	ScaleUp Sat	92,465	91%			49%	97%	58%
Homabay	COP16	ScaleUp Sat	98,500	95%	22%	29%	47%	92%	62%
Homabay	COP17	ScaleUp Sat	99,734	93%	30%	38%	47%	89%	63%
Homabay	COP18	ScaleUp Sat	117,833	98%	51%	58%	64%	92%	75%
Homabay	COP19	EVOLVE	117,957	89%	92%	100%	99%	73%	85%
Homabay	COP20	EVOLVE	115,992	198%	40%	72%	75%	83%	81%
Homabay	COP21	Scale-up: Saturation	118,697	102%	44%	92%	83%	87%	85%
Isiolo	COP15	Sustained Com	2,095	107%			71%	69%	58%
Isiolo	COP16	Sustained Com	2,176	107%	21%	18%	72%	65%	60%
Isiolo	COP17	Sustained Com	2,066	102%	20%	15%	67%	63%	57%
Isiolo	COP18	Sustained Com	2,386	102%	51%	51%	56%	72%	66%
Isiolo	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Isiolo	COP20	GOK/TRANSITION		161%	55%	48%	57%	54%	58%
Isiolo	COP21	Centrally Supported							
Kajiado	COP15	ScaleUp Agg	10,640	42%			46%	76%	52%
Kajiado	COP16	ScaleUp Agg	10,796	40%	31%	30%	44%	70%	53%
Kajiado	COP17	ScaleUp Agg	10,838	38%	38%	40%	43%	68%	53%
Kajiado	COP18	ScaleUp Agg	15,100	58%	62%	62%	62%	90%	75%
Kajiado	COP19	REBOOT	21,759	65%	65%	93%	76%	74%	75%
Kajiado	COP20	REBOOT	15,278	162%	35%	38%	40%	53%	49%
Kajiado	COP21	Sustained	15,991	64%	32%	38%	44%	58%	52%
Kakamega	COP15	ScaleUp Agg	35,526	86%			60%	92%	70%
Kakamega	COP16	ScaleUp Agg	38,467	92%	75%	83%	61%	80%	76%
Kakamega	COP17	ScaleUp Sat	38,613	89%	74%	85%	61%	81%	76%
Kakamega	COP18	ScaleUp Sat	45,506	99%	100%	91%	72%	97%	89%
Kakamega	COP19	EVOLVE	43,992	68%	80%	114%	87%	94%	90%
Kakamega	COP20	EVOLVE	44,297	400%	81%	54%	96%	86%	92%
Kakamega	COP21	Scale-up: Saturation	46,687	115%	44%	72%	82%	118%	100%

Kericho	COP15	Sustained	13,768	75%			81%	110%	84%
Kericho	COP16	Sustained	15,584	87%	104%	80%	76%	112%	95%
Kericho	COP17	Attained	16,279	88%	115%	86%	80%	116%	99%
Kericho	COP18	Sustained	17,169	89%	184%	86%	86%	118%	105%
Kericho	COP19	EVOLVE	19,205	89%	217%	134%	87%	85%	95%
Kericho	COP20	EVOLVE	15,979	152%	67%	60%	53%	84%	72%
Kericho	COP21	Scale-up: Aggressive	16,789	83%	61%	61%	65%	86%	76%
Kiambu	COP15	ScaleUp Agg	31,885	82%			60%	44%	45%
Kiambu	COP16	ScaleUp Sat	35,239	77%	61%	39%	59%	45%	50%
Kiambu	COP17	ScaleUp Agg	35,494	74%	51%	31%	60%	47%	50%
Kiambu	COP18	ScaleUp Agg	52,873	104%	63%	63%	63%	79%	75%
Kiambu	COP19	REBOOT	44,543	54%	68%	90%	64%	103%	85%
Kiambu	COP20	REBOOT	47,508	125%	88%	58%	63%	80%	75%
Kiambu	COP21	Scale-up: Saturation	43,881	78%	61%	72%	73%	101%	88%
Kilifi	COP15	ScaleUp Agg	20,566	84%			74%	82%	65%
Kilifi	COP16	ScaleUp Agg	20,663	80%	62%	43%	59%	72%	65%
Kilifi	COP17	ScaleUp Agg	21,030	83%	71%	56%	58%	70%	66%
Kilifi	COP18	ScaleUp Agg	23,564	99%	91%	57%	64%	79%	74%
Kilifi	COP19	REBOOT	29,982	107%	128%	97%	61%	71%	75%
Kilifi	COP20	REBOOT	26,500	229%	79%	60%	67%	70%	73%
Kilifi	COP21	Scale-up: Saturation	28,775	90%	41%	63%	63%	107%	87%
Kirinyaga	COP15	Sustained	8,415	119%			87%	69%	68%
Kirinyaga	COP16	Sustained	9,068	114%	60%	34%	92%	70%	74%
Kirinyaga	COP17	ScaleUp Sat	9,378	113%	61%	37%	91%	74%	76%
Kirinyaga	COP18	ScaleUp Sat	11,090	123%	76%	76%	96%	88%	90%
Kirinyaga	COP19	SCALE	10,670	59%	60%	80%	64%	100%	83%
Kirinyaga	COP20	SCALE	10,801	129%	92%	70%	64%	76%	73%
Kirinyaga	COP21	Scale-up: Aggressive	11,470	112%	75%	84%	94%	99%	97%
Kisii	COP15	ScaleUp Agg	25,737	113%			54%	135%	76%
Kisii	COP16	ScaleUp Sat	27,901	114%	34%	40%	55%	128%	82%
Kisii	COP17	ScaleUp Sat	28,176	110%	35%	41%	56%	130%	83%

Kisii	COP18	ScaleUp Sat	31,633	113%	43%	55%	76%	130%	93%
Kisii	COP19	REBOOT	32,055	65%	54%	64%	78%	71%	71%
Kisii	COP20	REBOOT	33,233	240%	52%	76%	60%	79%	75%
Kisii	COP21	Scale-up: Aggressive	36,345	129%	62%	117%	68%	85%	83%
Kisumu	COP15	ScaleUp Sat	92,212	86%			56%	105%	64%
Kisumu	COP16	ScaleUp Sat	97,973	87%	49%	38%	56%	92%	68%
Kisumu	COP17	ScaleUp Sat	98,770	85%	43%	37%	53%	98%	68%
Kisumu	COP18	ScaleUp Sat	108,227	92%	52%	60%	65%	92%	75%
Kisumu	COP19	EVOLVE	122,966	77%	112%	92%	83%	66%	76%
Kisumu	COP20	EVOLVE	111,032	220%	40%	55%	71%	83%	78%
Kisumu	COP21	Scale-up: Aggressive	118,067	115%	51%	84%	81%	91%	87%
Kitui	COP15	ScaleUp Agg	17,303	109%			57%	78%	60%
Kitui	COP16	ScaleUp Sat	17,470	104%	30%	19%	59%	71%	60%
Kitui	COP17	ScaleUp Sat	17,591	101%	32%	21%	52%	74%	61%
Kitui	COP18	ScaleUp Sat	25,882	109%	73%	73%	73%	101%	90%
Kitui	COP19	SCALE	22,166	95%	77%	119%	59%	75%	75%
Kitui	COP20	SCALE	21,959	179%	113%	48%	65%	64%	68%
Kitui	COP21	Scale-up: Aggressive	23,801	104%	58%	53%	84%	87%	83%
Kwale	COP15	ScaleUp Agg	7,501	44%			34%	40%	31%
Kwale	COP16	ScaleUp Agg	8,063	45%	52%	46%	25%	31%	34%
Kwale	COP17	ScaleUp Agg	8,255	42%	27%	27%	30%	38%	35%
Kwale	COP18	ScaleUp Agg	17,807	75%	61%	61%	61%	85%	75%
Kwale	COP19	REBOOT	16,959	115%	84%	102%	57%	75%	75%
Kwale	COP20	REBOOT	12,259	214%	92%	81%	55%	60%	65%
Kwale	COP21	Scale-up: Saturation	13,747	105%	42%	63%	68%	83%	78%
Laikipia	COP15	Sustained	6,895	87%			83%	122%	89%
Laikipia	COP16	Sustained	7,692	88%	76%	53%	78%	128%	99%
Laikipia	COP17	ScaleUp Agg	7,814	88%	108%	53%	89%	122%	101%
Laikipia	COP18	ScaleUp Agg	5,933	75%	78%	55%	62%	91%	76%
Laikipia	COP19	SCALE	8,796	124%	86%	83%	77%	75%	81%

Laikipia	COP20	SCALE	8,851	283%	100%	84%	70%	99%	92%
Laikipia	COP21	Scale-up: Saturation	9,287	94%	78%	74%	72%	87%	82%
Lamu	COP15	Sustained Com	1,125	78%			61%	56%	49%
Lamu	COP16	Sustained Com	1,218	69%	59%	42%	54%	52%	53%
Lamu	COP17	Sustained Com	1,222	63%	24%	25%	62%	57%	53%
Lamu	COP18	Sustained Com	1,379	75%	46%	46%	46%	68%	59%
Lamu	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Lamu	COP20	GOK/TRANSITION		170%	85%	87%	58%	71%	70%
Lamu	COP21	Centrally Supported							
Machakos	COP15	ScaleUp Agg	21,477	101%			75%	83%	66%
Machakos	COP16	ScaleUp Sat	22,063	91%	40%	22%	72%	79%	68%
Machakos	COP17	ScaleUp Sat	22,435	93%	44%	25%	70%	80%	69%
Machakos	COP18	ScaleUp Sat	29,187	102%	74%	74%	74%	101%	90%
Machakos	COP19	SCALE	27,310	98%	94%	141%	70%	89%	88%
Machakos	COP20	SCALE	27,975	161%	97%	51%	64%	71%	71%
Machakos	COP21	Scale-up: Aggressive	29,117	85%	54%	55%	72%	82%	77%
Makueni	COP15	ScaleUp Agg	15,012	87%			53%	66%	51%
Makueni	COP16	ScaleUp Sat	15,234	84%	24%	16%	51%	61%	52%
Makueni	COP17	ScaleUp Sat	15,367	80%	26%	19%	50%	62%	52%
Makueni	COP18	ScaleUp Sat	26,286	98%	75%	75%	75%	101%	90%
Makueni	COP19	SCALE	19,012	97%	80%	120%	59%	74%	75%
Makueni	COP20	SCALE	19,131	189%	116%	59%	75%	72%	76%
Makueni	COP21	Scale-up: Saturation	20,816	117%	68%	68%	96%	99%	96%
Mandera	COP15	Sustained Com	481	5%			52%	14%	14%
Mandera	COP16	Sustained Com	513	7%	45%	22%	33%	9%	15%
Mandera	COP17	Sustained Com	525	8%	48%	22%	35%	9%	16%
Mandera	COP18	Sustained Com	542	50%	46%	12%	7%	7%	16%
Mandera	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Mandera	COP20	GOK/TRANSITION		25%	37%	27%	48%	47%	44%
Mandera	COP21	Centrally Supported							

Marsabit	COP15	Sustained Com	1,421	79%			54%	64%	50%
Marsabit	COP16	Sustained Com	1,205	47%	106%	78%	39%	27%	42%
Marsabit	COP17	Sustained Com	1,219	57%	106%	79%	29%	31%	43%
Marsabit	COP18	Sustained Com	1,352	85%	110%	79%	41%	31%	48%
Marsabit	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Marsabit	COP20	GOK/TRANSITION		82%	52%	28%	35%	39%	39%
Marsabit	COP21	Centrally Supported							
Meru	COP15	ScaleUp Agg	17,066	101%			81%	80%	66%
Meru	COP16	ScaleUp Sat	16,994	86%	40%	29%	77%	71%	65%
Meru	COP17	ScaleUp Sat	17,007	82%	39%	22%	75%	74%	65%
Meru	COP18	ScaleUp Sat	23,287	108%	73%	73%	90%	93%	89%
Meru	COP19	SCALE	20,193	81%	81%	125%	80%	77%	82%
Meru	COP20	SCALE	21,248	159%	105%	57%	55%	61%	63%
Meru	COP21	Sustained	22,819	109%	66%	68%	76%	89%	84%
Migori	COP15	ScaleUp Sat	59,912	107%			57%	122%	72%
Migori	COP16	ScaleUp Sat	64,577	113%	34%	47%	56%	111%	77%
Migori	COP17	ScaleUp Sat	65,673	113%	32%	46%	58%	114%	79%
Migori	COP18	ScaleUp Sat	72,317	108%	45%	62%	76%	110%	87%
Migori	COP19	EVOLVE	79,087	78%	69%	92%	96%	73%	82%
Migori	COP20	EVOLVE	75,201	242%	39%	88%	75%	91%	88%
Migori	COP21	Scale-up: Saturation	77,953	118%	42%	110%	82%	94%	90%
Mombasa	COP15	ScaleUp Sat	40,885	71%			106%	90%	75%
Mombasa	COP16	ScaleUp Sat	43,018	63%	133%	81%	85%	74%	79%
Mombasa	COP17	ScaleUp Sat	42,678	54%	53%	31%	103%	86%	79%
Mombasa	COP18	ScaleUp Sat	48,879	90%	150%	88%	87%	86%	90%
Mombasa	COP19	EVOLVE	50,054	97%	243%	172%	97%	91%	105%
Mombasa	COP20	EVOLVE	44,795	155%	56%	43%	54%	85%	71%
Mombasa	COP21	Scale-up: Aggressive	47,267	88%	63%	56%	89%	95%	89%
Murang'a	COP15	ScaleUp Agg	11,648	89%			57%	42%	43%
Murang'a	COP16	ScaleUp Agg	12,970	91%	42%	27%	56%	45%	48%

Murang'a	COP17	ScaleUp Agg	13,096	85%	55%	28%	58%	45%	48%
Murang'a	COP18	ScaleUp Agg	20,297	85%	65%	65%	65%	79%	75%
Murang'a	COP19	SCALE	20,220	40%	64%	84%	56%	91%	75%
Murang'a	COP20	SCALE	16,354	133%	109%	80%	66%	74%	74%
Murang'a	COP21	Scale-up: Aggressive	17,610	100%	74%	93%	85%	100%	94%
Nairobi	COP15	ScaleUp Sat	125,705	94%			68%	96%	73%
Nairobi	COP16	ScaleUp Sat	141,541	92%	69%	52%	70%	98%	83%
Nairobi	COP17	ScaleUp Sat	142,560	90%	60%	46%	71%	100%	83%
Nairobi	COP18	ScaleUp Sat	158,678	100%	82%	82%	82%	102%	93%
Nairobi	COP19	EVOLVE	199,527	65%	144%	106%	93%	106%	101%
Nairobi	COP20	EVOLVE	163,751	160%	118%	80%	80%	97%	92%
Nairobi	COP21	Scale-up: Saturation	166,267	95%	98%	81%	98%	108%	103%
Nakuru	COP15	ScaleUp Agg	32,336	71%			72%	110%	78%
Nakuru	COP16	ScaleUp Agg	35,530	69%	57%	48%	74%	109%	86%
Nakuru	COP17	ScaleUp Sat	35,757	68%	58%	49%	75%	110%	87%
Nakuru	COP18	ScaleUp Sat	41,217	90%	81%	81%	81%	121%	100%
Nakuru	COP19	REBOOT	43,427	72%	64%	91%	74%	75%	75%
Nakuru	COP20	REBOOT	42,051	219%	59%	50%	64%	66%	67%
Nakuru	COP21	Scale-up: Aggressive	43,524	86%	57%	55%	66%	82%	75%
Nandi	COP15	ScaleUp Agg	9,442	69%			80%	118%	84%
Nandi	COP16	ScaleUp Agg	10,296	77%	70%	39%	88%	113%	92%
Nandi	COP17	ScaleUp Agg	10,579	75%	56%	36%	86%	121%	94%
Nandi	COP18	ScaleUp Agg	11,266	86%	82%	59%	91%	121%	100%
Nandi	COP19	SCALE	12,066	77%	101%	76%	70%	87%	81%
Nandi	COP20	SCALE	11,591	172%	46%	45%	44%	64%	58%
Nandi	COP21	Sustained	12,167	65%	47%	38%	52%	69%	60%
Narok	COP15	ScaleUp Agg	6,985	50%			41%	59%	44%
Narok	COP16	ScaleUp Agg	7,804	49%	31%	26%	55%	61%	49%
Narok	COP17	ScaleUp Agg	7,870	53%	35%	29%	41%	61%	50%
Narok	COP18	ScaleUp Agg	11,838	86%	56%	56%	56%	90%	75%

Narok	COP19	REBOOT	15,453	82%	57%	80%	65%	70%	70%
Narok	COP20	REBOOT	9,961	124%	27%	38%	31%	49%	43%
Narok	COP21	Sustained	10,249	62%	35%	41%	45%	59%	52%
Nyamira	COP15	ScaleUp Agg	12,257	81%			36%	89%	50%
Nyamira	COP16	ScaleUp Agg	13,055	83%	34%	41%	35%	75%	54%
Nyamira	COP17	ScaleUp Sat	13,207	82%	34%	42%	35%	76%	54%
Nyamira	COP18	ScaleUp Sat	21,799	97%	79%	79%	79%	104%	90%
Nyamira	COP19	SCALE	16,883	80%	109%	98%	86%	59%	75%
Nyamira	COP20	SCALE	14,009	352%	74%	83%	72%	87%	87%
Nyamira	COP21	Scale-up: Saturation	17,294	225%	101%	164%	96%	110%	112%
Nyandarua	COP15	Sustained	6,873	142%			70%	52%	54%
Nyandarua	COP16	Sustained	7,299	134%	67%	34%	67%	52%	57%
Nyandarua	COP17	ScaleUp Sat	7,330	126%	92%	45%	71%	49%	57%
Nyandarua	COP18	ScaleUp Sat	11,478	181%	69%	69%	69%	95%	90%
Nyandarua	COP19	SCALE	10,640	67%	55%	72%	50%	93%	75%
Nyandarua	COP20	SCALE	9,749	134%	109%	77%	70%	77%	78%
Nyandarua	COP21	Scale-up: Saturation	10,264	110%	81%	91%	103%	109%	105%
Nyeri	COP15	Sustained	15,085	147%			111%	79%	81%
Nyeri	COP16	Sustained	15,904	128%	94%	48%	102%	81%	85%
Nyeri	COP17	ScaleUp Sat	15,949	122%	112%	48%	108%	79%	85%
Nyeri	COP18	ScaleUp Sat	16,720	157%	98%	52%	103%	85%	90%
Nyeri	COP19	EVOLVE	17,124	89%	98%	63%	86%	95%	90%
Nyeri	COP20	EVOLVE	18,633	105%	120%	76%	61%	77%	73%
Nyeri	COP21	Scale-up: Aggressive	18,909	80%	86%	80%	85%	92%	89%
Samburu	COP15	Sustained	1,092	63%			30%	48%	37%
Samburu	COP16	Sustained	1,399	79%	74%	131%	27%	31%	47%
Samburu	COP17	Sustained	1,424	83%	96%	126%	30%	29%	48%
Samburu	COP18	Sustained	1,750	70%	96%	136%	48%	42%	59%
Samburu	COP19	REBOOT	2,669	78%	131%	263%	73%	45%	74%
Samburu	COP20	REBOOT	1,770	257%	41%	63%	54%	79%	74%

Samburu	COP21	Scale-up: Saturation	1,870	95%	40%	50%	54%	70%	64%
Siaya	COP15	ScaleUp Sat	73,440	87%			49%	97%	58%
Siaya	COP16	ScaleUp Sat	78,891	91%	37%	34%	47%	88%	62%
Siaya	COP17	ScaleUp Sat	79,399	90%	31%	29%	49%	91%	63%
Siaya	COP18	ScaleUp Sat	94,630	99%	60%	63%	64%	88%	75%
Siaya	COP19	EVOLVE	95,346	81%	113%	112%	99%	72%	87%
Siaya	COP20	EVOLVE	93,597	215%	31%	63%	69%	88%	81%
Siaya	COP21	Scale-up: Saturation	99,205	132%	44%	97%	90%	98%	95%
Taita Taveta	COP15	Sustained	4,955	42%			55%	52%	42%
Taita Taveta	COP16	Sustained	4,880	34%	23%	11%	49%	49%	41%
Taita Taveta	COP17	Sustained	4,983	39%	30%	12%	51%	48%	42%
Taita Taveta	COP18	Sustained	6,012	55%	41%	23%	52%	58%	51%
Taita Taveta	COP19	REBOOT	9,003	88%	86%	58%	72%	77%	75%
Taita Taveta	COP20	REBOOT	6,848	163%	102%	85%	56%	77%	72%
Taita Taveta	COP21	Scale-up: Saturation	7,621	118%	79%	81%	84%	81%	83%
Tana River	COP15	Sustained Com	894	41%			35%	41%	32%
Tana River	COP16	Sustained Com	1,008	44%	62%	50%	28%	32%	36%
Tana River	COP17	Sustained Com	1,020	46%	58%	49%	30%	33%	37%
Tana River	COP18	Sustained Com	1,061	61%	47%	38%	29%	38%	38%
Tana River	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Tana River	COP20	GOK/TRANSITION		116%	40%	53%	41%	63%	56%
Tana River	COP21	Centrally Supported							
Tharaka Nithi	COP15	Sustained	5,878	86%			85%	78%	65%
Tharaka Nithi	COP16	Sustained	5,950	77%	48%	24%	76%	73%	65%
Tharaka Nithi	COP17	ScaleUp Sat	6,013	76%	44%	23%	79%	74%	66%
Tharaka Nithi	COP18	ScaleUp Sat	8,138	98%	75%	75%	89%	94%	90%
Tharaka Nithi	COP19	SCALE	7,061	64%	89%	134%	79%	77%	81%

Tharaka Nithi	COP20	SCALE	7,253	194%	163%	69%	88%	76%	83%
Tharaka Nithi	COP21	Scale-up: Saturation	7,563	105%	96%	78%	106%	102%	102%
Trans Nzoia	COP15	ScaleUp Agg	12,968	48%			41%	72%	50%
Trans Nzoia	COP16	ScaleUp Sat	13,665	45%	36%	30%	45%	65%	52%
Trans Nzoia	COP17	ScaleUp Sat	13,280	41%	46%	26%	42%	65%	51%
Trans Nzoia	COP18	ScaleUp Sat	23,417	90%	71%	71%	71%	108%	90%
Trans Nzoia	COP19	REBOOT	23,663	80%	57%	82%	67%	70%	70%
Trans Nzoia	COP20	REBOOT	16,328	160%	42%	44%	44%	53%	52%
Trans Nzoia	COP21	Sustained	18,421	88%	49%	58%	64%	78%	72%
Turkana	COP15	ScaleUp Agg	6,205	36%			28%	34%	28%
Turkana	COP16	ScaleUp Agg	7,253	42%	90%	36%	22%	31%	32%
Turkana	COP17	ScaleUp Agg	7,212	42%	95%	36%	22%	30%	32%
Turkana	COP18	ScaleUp Agg	16,780	75%	131%	59%	52%	89%	75%
Turkana	COP19	REBOOT	19,188	84%	130%	83%	61%	70%	72%
Turkana	COP20	REBOOT	8,594	114%	21%	35%	33%	40%	39%
Turkana	COP21	Sustained	11,038	100%	26%	51%	57%	62%	60%
Uasin Gishu	COP15	ScaleUp Sat	27,444	81%			100%	142%	103%
Uasin Gishu	COP16	ScaleUp Sat	29,164	77%	78%	61%	99%	137%	109%
Uasin Gishu	COP17	ScaleUp Sat	29,244	79%	81%	44%	99%	141%	109%
Uasin Gishu	COP18	ScaleUp Sat	31,604	100%	97%	87%	101%	143%	118%
Uasin Gishu	COP19	SCALE	31,024	66%	73%	91%	87%	82%	82%
Uasin Gishu	COP20	SCALE	31,566	155%	59%	45%	54%	68%	63%
Uasin Gishu	COP21	Sustained	33,076	70%	62%	50%	69%	82%	74%
Vihiga	COP15	Sustained	12,685	87%			60%	83%	65%
Vihiga	COP16	Sustained	13,035	90%	63%	70%	56%	70%	67%
Vihiga	COP17	ScaleUp Sat	13,054	82%	64%	71%	56%	71%	67%
Vihiga	COP18	ScaleUp Sat	17,346	100%	71%	71%	71%	103%	90%
Vihiga	COP19	SCALE	15,426	69%	61%	84%	80%	92%	84%
Vihiga	COP20	SCALE	16,181	306%	77%	61%	75%	74%	79%
Vihiga	COP21	Scale-up: Saturation	18,509	129%	70%	84%	89%	106%	99%

Wajir	COP15	Sustained Com	214	8%			51%	18%	17%
Wajir	COP16	Sustained Com	249	11%	65%	41%	31%	10%	19%
Wajir	COP17	Sustained Com	258	11%	68%	43%	32%	10%	20%
Wajir	COP18	Sustained Com	252	50%	27%	17%	13%	13%	20%
Wajir	COP19	GOK/TRANSITION		0%	0%	0%	0%	0%	0%
Wajir	COP20	GOK/TRANSITION							
Wajir	COP21	Centrally Supported							
West Pokot	COP15	Sustained	2,173	42%			42%	63%	45%
West Pokot	COP16	Sustained	3,201	97%	166%	101%	41%	61%	67%
West Pokot	COP17	Sustained	3,523	89%	206%	113%	42%	71%	74%
West Pokot	COP18	Sustained	3,880	77%	173%	108%	67%	77%	81%
West Pokot	COP19	REBOOT	5,238	64%	165%	151%	73%	59%	75%
West Pokot	COP20	REBOOT	2,689	131%	31%	43%	44%	67%	58%
West Pokot	COP21	Scale-up: Aggressive	3,962	97%	52%	68%	91%	118%	101%

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 Budget by Program, Sub-Program, and Interaction Type

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Table B.1.2 COP21 Budget by Program Area

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$146,707,020**	**$236,231,980**	**$382,939,000**	**38.31%**	**61.69%**	**100.00%**
C&T	**Total**	**$37,084,719**	**$156,053,609**	**$193,138,328**	**19.20%**	**80.80%**	**100.00%**
	HIV Clinical Services	$6,205,487	$26,218,560	**$32,424,047**	19.14%	80.86%	**100.00%**
	HIV Drugs	$3,636,305	$46,643,204	**$50,279,509**	7.23%	92.77%	**100.00%**
	HIV Laboratory Services	$3,419,159	$24,267,760	**$27,686,919**	12.35%	87.65%	**100.00%**
	Not Disaggregated	$23,823,768	$58,924,085	**$82,747,853**	28.79%	71.21%	**100.00%**
HTS	**Total**	**$3,224,765**	**$14,548,849**	**$17,773,614**	**18.14%**	**81.86%**	**100.00%**
	Community-based testing	$117,876		**$117,876**	100.00%		**100.00%**
	Facility-based testing	$420,558	$3,335,982	**$3,756,540**	11.20%	88.80%	**100.00%**
	Not Disaggregated	$2,686,331	$11,212,867	**$13,899,198**	19.33%	80.67%	**100.00%**
PREV	**Total**	**$5,354,163**	**$23,504,450**	**$28,858,613**	**18.55%**	**81.45%**	**100.00%**
	Comm. mobilization, behavior & norms change	$156,766	$6,872,848	**$7,029,614**	2.23%	97.77%	**100.00%**
	Medication assisted treatment	$475,824	$363,725	**$839,549**	56.68%	43.32%	**100.00%**
	Not Disaggregated	$2,433,743	$8,531,685	**$10,965,428**	22.19%	77.81%	**100.00%**
	PrEP	$1,339,890	$4,811,261	**$6,151,151**	21.78%	78.22%	**100.00%**
	VMMC	$947,940	$2,924,931	**$3,872,871**	24.48%	75.52%	**100.00%**
SE	**Total**	**$2,918,547**	**$42,125,072**	**$45,043,619**	**6.48%**	**93.52%**	**100.00%**
	Case Management		$4,665,130	**$4,665,130**		100.00%	**100.00%**
	Economic strengthening		$26,162,327	**$26,162,327**		100.00%	**100.00%**
	Education assistance		$10,091,940	**$10,091,940**		100.00%	**100.00%**
	Legal, human rights & protection	$14,238	$439,046	**$453,284**	3.14%	96.86%	**100.00%**
	Not Disaggregated	$2,904,309	$766,629	**$3,670,938**	79.12%	20.88%	**100.00%**
ASP	**Total**	**$26,560,786**		**$26,560,786**	**100.00%**		**100.00%**
	HMIS, surveillance, & research	$11,569,729		**$11,569,729**	100.00%		**100.00%**
	Human resources for health	$2,506,711		**$2,506,711**	100.00%		**100.00%**

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
	Laboratory systems strengthening	$5,017,485		**$5,017,485**	100.00%		**100.00%**
	Not Disaggregated	$920,656		**$920,656**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$3,101,857		**$3,101,857**	100.00%		**100.00%**
	Procurement & supply chain management	$2,921,348		**$2,921,348**	100.00%		**100.00%**
	Public financial management strengthening	$523,000		**$523,000**	100.00%		**100.00%**
PM	**Total**	**$71,564,040**		**$71,564,040**	**100.00%**		**100.00%**
	IM Closeout costs	$460,000		**$460,000**	100.00%		**100.00%**
	IM Program Management	$43,197,681		**$43,197,681**	100.00%		**100.00%**
	USG Program Management	$27,906,359		**$27,906,359**	100.00%		**100.00%**

Table B.1.3 COP21 Total Planning Level

Fiscal Year	2022	2022	2022
Metrics	Proposed COP21 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	**$19,735,303**	**$363,203,697**	**$382,939,000**
Kenya	$19,735,303	$363,203,697	**$382,939,000**

APPENDIX C – Tables and Systems Investments for Section 6.0

See attached files.

APPENDIX D– Minimum Program Requirements

The minimum program requirements (MPRs) for continued PEPFAR support include:

Program	MPR	Progress
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[a]	Completed
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥35 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[b]	Kenya has actively transitioned women of child bearing potential to TLD and there is now near universal coverage of TLD within this population. Guidelines revision to incorporate DTG for children >20kg is currently underway and rollout is expected in June/July after guidelines revision and training. All nevirapine based regimens have been removed
	3. Adoption and implementation of differentiated service delivery (DSD) models, including six-month MMD/MMS and delivery models to improve identification and ARV coverage of men and adolescents.[c]	Kenya has national DSD guidelines that were released in 2016 and a majority of patients are on MMD and multi-month prescriptions. In COP21, the country will revise national DSD guidelines on criteria for DSD and community models. Commodity forecasting and procurement will be done to ensure adequate stock to support MMD/MMS. There is an ongoing guidelines review exercise which is expected to incorporate 6-month MMD/MMS for stable clients and to extend MMD to children, adolescents, PBFW, and clients who may not be virally suppressed.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP21, and co-trimoxazole, where indicated,	Kenya is meeting this requirement. It has a policy in place and implementation in progress with over 90% of all PLHIV in care and treatment having been initiated on TPT. In COP21, the country will focus on

	must be fully integrated into the HIV clinical care package at no cost to the patient.[d]	ensuring capacity within the GOK to mop up the remaining cohort of PLHIV eligible for TPT, ensuring improved documentation, reporting, and strengthening of pharmacovigilance. The country will also focus on finalization of policy change and guidelines and introduction of 3HP
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	This is ongoing. Ministry of Health has successfully completed VL/EID optimization activities (e.g., testing, receipt of results, networks) and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children aged <19 years with an HIV positive biological parent must be tested for HIV.[e]	This policy is done. Implementation is in progress. Kenya HTS guidelines (reprint 2016) include index testing as a promising modality. In addition, Kenya launched *HIV Self-Testing and Assisted Partner Notification Services* guidance document in 2019 that emphasizes implementation of the 5Cs of testing and principles of index testing (pg. 49-50). Kenya is developing an enhanced guidance document for index testing that includes consent procedures emphasizing confidentiality and enhanced monitoring of intimate partner violence (IPV). The draft language is to be included in a Ministry of Health circular to all counties and health facilities on scaling up index testing with fidelity and safeguards. This language was discussed and agreed upon with GOK representatives on March 5, 2020 at the Johannesburg COP meeting.
Prevention and OVC	1. Direct and immediate assessment for - and offer of -prevention services, including pre-exposure prophylaxis (PrEP), to HIV negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV negative partners of	Kenya has adopted and plans to offer combination prevention services including HIV prevention and is in the process of establishing prevention centers for community education, assessment, and provision of prevention services including PrEP and referral. The national AART policy guidelines developed in 2016

	index cases, KP and adult men engaged in high-risk sex practices*).* [f]	provides for the provision of PrEP to any individual who is at substantial risk of acquiring HIV regardless of population, provided they meet the eligibility criteria. The guidelines provide for PrEP provision both at the community and in health facilities. Via COP21, Kenya is expanding the provision of PrEP by integrating service provision into the key service provision areas among highly vulnerable populations. Using targeted HTS as a platform, clients will be screened and tested and the vulnerable sero-negative individuals evaluated for suitability and offered PrEP. Specific targets have been allocated in COP21 for the most vulnerable populations including MNCH and KP clients in addition to the discordant and AGYW populations. Kenya has conducted a study on the provision of PrEP in MNCH to PBFW and important lessons were learnt. Services will be scaled up in 2020 to achieve integration. A combination prevention will be followed to allow for choice and fidelity.
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC aged 0-17 years, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection; 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV; 3) reducing risk for adolescent girls in high HIV-burden areas and for girls and boys aged 9-14 years in regard to primary prevention of sexual violence and HIV.	Kenya is addressing the requirement of ensuring that all the eligible OVC are identified, assessed, enrolled, and served with an appropriate package of comprehensive and preventive services. Family-centered case management and tracking of graduation benchmarks will take place. In COP21, Kenya will ensure that the distinct, comprehensive package of services for families with known risks as well as preventive services are well defined and implemented. COP21 will further support Kenya facilitating access to HTS for at-risk OVC, ensuring those who are HIV positive are linked to treatment, monitoring

		adherence and viral suppression (including that of HIV positive caregivers with sub-optimal continuity of treatment as a safeguard for children). Kenya is also focused on primary prevention of HIV and violence targeting pre-and adolescent boys and girls aged 9-14 years with interventions that prevent violence, delay sexual debut and prevent HIV, using evidence-based materials that also target families and communities.
Policy and Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[g]	All HIV, TB and related services are free in all public health facilities. Under the UHC roll out, this will be extended to include more services in all public health facilities.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[h]	Kenya has institutionalized QM systems, plans and workforce capacities to ensure continuous program and service delivery QI. While the health ministry now has a national QA framework to guide implementation, cascading and sustaining gains to county level for service delivery and laboratory QA systems remains an area of focus. The IPs will support HIV/AIDs related CQI activities through their workplans, similarly the same will be incorporated in county MOU documents.
	3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	This is an activity that is in progress and has been prioritized in COP21. PEPFAR has had discussions with Ministry of Health through NASCOP and NACC, and CSOs through NEPHAK, on how to continue supporting this activity. The priority activities are demand creation and provision of IEC materials across the counties. PEPFAR Kenya has set aside resources through the Ministry of Health COAG to support these activities in this COP.

	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Agencies are working toward awarding more agreements and contracts to local partners for service delivery and systems strengthening. This is reflected in the new awards and designs for the various agencies. Discussion are on course to have the county government receive direct funding to implement various awards.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year-after-year increased resources expended.	While public sector contributions to HIV/AIDS have increased from 18.8% in Kenya Fiscal Year (KFY) 2012/13 to 22.1% in KFY 2015/16, donors remain the predominant source of HIV financing, contributing 62.3% of HIV expenditures in KFY 2015/16. The remainder of shares are borne by households through out-of-pocket spending and employers at 9% and 6.5% respectively. Kenya's contribution as part of its Global Fund (GF) counterpart-financing requirement was $22 million in 2017/18 and $25 million in 2018/19 for procurement of ARVs and test kits and is expected to increase by $25.4 million in KFY 2019/20 as shown by the budget estimates presented to the National Assembly. This is further expected to increase to $31 million by KFY20/21 . Nevertheless, donors continue to finance the majority (75% in KFY 2019/20 down from 86.4% in KFY 2018/19) of all ARV needs and all HIV test kits in Kenya.

	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Kenya is meeting the requirement. Ongoing National Case Based Surveillance includes collection of sentinel morbidity and mortality outcomes. Additionally, Kenya has disseminated findings of mortuary-based surveillance in two counties (Nairobi in 2015 and Kisumu in 2019) and used this experience in COP20 to develop guidelines and a protocol for routine mortuary-based HIV surveillance in the country. COP21 will focus on implementation of routine surveillance for HIV-associated mortality at sentinel mortuaries and support for the dissemination and use of findings to guide public health response at National and County levels.
	7. Scale-up of case-based surveillance (CBS) and unique identifiers for patients across all sites.	Kenya is meeting the requirement. In COP20, routine CBS has thus far been rolled out to 23 counties with periodic data reviews and reports for all activated counties ongoing. CBS roll-out leverages existing M&E systems and the already established NDWH for data. CBS guidelines are now available to all health workers via the link https://surveillance.nascop.org/cbs-guidelines. Additionally, a series of four CBS eLearning courses were launched to support efficient capacity building at health facility, sub-county and county levels. CBS e-learning Modules are available upon registration via https://surveillance.nascop.org/. COP21 will focus on sustained CBS data collection, use and quality improvement among activated counties, rolling out CBS to remaining counties (40 PEPFAR-supported counties in total with plans to roll out to the 7 non-PEPFAR supported counties through leveraging on GF resources), and expanding CBS in health facilities with paper-based records systems. All the 47 counties will be centrally

		supported in TA and provision of eLearning materials and guidelines. Capacity building for effective public health response using CBS data is an additional COP21 priority to foster data used for decision making. The dashboards (referred to above) will be highly instrumental in this process. The Unique Patient Identifier (UPI) policy framework draft has been completed and reviewed by the different government departments within the relevant ministries of health, interior and ICT. The Draft has been shared with stakeholders for input, whereas several of the stakeholders have provided their comments others have requested for additional engagements and this is being coordinated through MOH. Activities planned for COP20 include UPI framework approval, generation of master patient index, phased UPI implementation in pilot counties, enrollment, and interoperability. In COP21, there will be continual engagement with stakeholders to review implementation progress, strengthen UPI use within the HIS space, develop plans for use in paper-based sites, and continue engagement with M&E teams on data validation & verification resulting from client level data deduplications during UPI implementation.

[a] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[b] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

[c] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[d] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

[e] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[f] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

[g] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[h] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

Site Level MPRs Related to Linkage and Continuity of treatment

During FY20 (COP19 implementation), all OUs are expected to fully implement continuity of treatment-related PEPFAR MPRs at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP21 planning. In addition, an effective tracking and tracing system must be in place at each site.

	MPRs
1.	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
2.	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥35 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.
3.	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector to ensure access to all direct HIV services and medications, and related services, such as ANC, TB, co-trimoxazole, cervical cancer, PrEP and routine clinical services.
4.	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up locations and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.

APPENDIX E – PEPFAR Kenya ARPA Funding Proposal

CATEGORY I: Prevent, prepare for, and respond to coronavirus in the context of PEPFAR programs (including prevention of COVID-19 infection, illness, and death among PEPFAR Beneficiaries and staff)

1A: Infection Prevention and Control Programming (IPC)

- Comprehensive IPC at PEPFAR-Supported Sites

Description of activity: This activity requests funds of $3,842,500. The budget will provide support for comprehensive IPC in PEPFAR-supported sites. This support includes site level-engineering, administrative, and environmental interventions to reduce COVID-19 infection. Other support includes providing PPE for health care workers and patients, minor infrastructure changes, procurement of tents, and hand hygiene support.

Description of how this activity is responsive to the category: This activity is aimed at protecting staff and patients in PEPFAR-supported sites against COVID-19.

How does this activity support or protect PEPFAR services?: This activity will prevent PEPFAR support staff from acquiring COVID-19, enabling them to continue providing essential services during the pandemic. It will also prevent infections among vulnerable patients, thereby reducing morbidity and mortality. Implementation of this activity will boost the confidence of health providers and patients when providing and accessing care at PEPFAR-supported sites, thereby 1) reducing service disruptions; 2) enabling the PEPFAR Kenya program to achieve its COP21 targets; and 3) providing much needed services to the recipients of care.

What is the timing to implement and complete this activity?: This activity will be implemented under the current COP20 and COP21.

Relevant estimated targets: N/A

Impact statement: This activity is expected to strengthen national-level COVID-19 coordination and reduce facility transmission of COVID-19. In addition, the activities will reduce service interruptions in PEPFAR-supported sites due to COVID-19 infections and boost confidence in the safety of facilities to offer essential HIV services without the risk of getting COVID-19. This will improve PEPFAR Kenya's indicators.

Gaps filled: Activities will complement support to national IPC measures by bridging current unmet needs through guideline review, capacity building, and reporting systems based on new evidence. This support will also complement the current IPC programs at health facility level by bridging current unmet need among frontline health workers. Some HIV treatment facilities and service delivery points do not yet receive adequate IPC support from the Ministry of Health.

Non-duplication and coordination statement: PEPFAR Kenya will coordinate with other funding mechanisms supporting COVID-19 funding. PEPFAR Kenya is taking part in proposal development for the C19RM Global Fund funds request and will share the proposed work plan and activities with other funding mechanisms.

- IPC at Special Sites (Prisons and Military Camps)

Description of activity: Funding requested for this activity is $400,000 on behalf of IPC in prisons and military camps.

Description of how this activity is responsive to the category: Kenya prisons are congested at 170% of design capacity. Quarantine facilities are at 300% of design capacity. Social distancing is impracticable and outbreaks with attack rates >90% have been reported. High rates of transmission have been reported among the 30,000 Kenya prisons and 40,000 military staff owing to congestion and close contact related to the work environment. This activity will expand quarantine facilities and create "green zones" for protection of the elderly and other vulnerable individuals. Prison wards will be renovated, tents supplied, and capacity built for the Kenya prisons' industry to carry out sustainable in-house production of reusable masks

How does this activity support or protect PEPFAR services?: Congestion in military and prison camps has led to COVID-19 outbreaks. High positivity rates and a lack of PPE at these sites pose a substantial risk of transmission within and across prisons and military camps, as well as associated communities. This has negatively impacted TB screening, HIV testing and screening, and management of other common conditions

What is the timing to implement and complete this activity? This activity will be completed in FY22.

Relevant estimated targets: All prisons, military camps and related health facilities.

Impact statement: The high burden of COVID-19 in military and prison camps has led to de-prioritization of other health service delivery including HIV and TB screening and testing, reduction in adherence counselling and psychosocial support services, and closure of mental health clinics. This has been associated with nearly 50% decline in case detection and an upsurge of mental illness in these settings. Negative stress coping mechanisms including drug abuse have been reported among staff and inmates potentially increasing the risk of HIV transmission. Delay in TB/HIV diagnosis coupled with an increase in risk of transmission and suboptimal quality of care could potentially reverse the gains made in HIV and TB epidemic control in these settings.

Investment in COVID-19 control in these setting will not only reduce the burden of COVID-19 but improve access to TB and HIV case finding and retention in care of clients in PEPFAR programs. There has been a decline in HIV and TB case-finding, and an upsurge psychiatric morbidity. This activity will improve access to TB/HIV case-finding and retention in care, and facilitate access to services that prevent negative stress coping mechanisms and HIV transmission including use of drugs and high-risk sexual behavior.

The impact of the intervention on COVID-19, HIV and TB programs will be tracked via MER and indicators collected using the national COVID-19 data collection tools. A protocol will be developed to facilitate collection of additional data including bidirectional HIV/TB/COVID-19 screening, yield of cases, coinfection and attack rates in COVID-19 over time.

Gap this fills: The COVID-19 response at the Kenya Defense Forces and at prisons are coordinated through a technical working group (TWG) that includes development and implementing partners. This has facilitated resource mapping to reduce duplication and maximize synergies. Meetings are held monthly to review progress, identify gaps, and develop mitigation measures. This request will complement what is already provided by other partners.

Non duplication and coordination statement: This activity is not expected to be duplicative with other agencies

1C Testing PEPFAR-supported staff and beneficiaries for COVID-19 and to inform both PEPFAR IPC practices and epidemiologic surveillance.

- Testing – Expanded Access

Description of activity: The funding request for this activity is $500,000. Kenya prison quarantine and other facilities are highly congested and the lack of space makes it difficult to hold inmates in isolation to curb transmission. In addition, the military is a highly mobile population due to duty requirements. Rapid testing and isolation of infectious cases are needed to prevent COVID-19 transmission. Funds will be used to procure rapid antigen-test kits and training of uniformed laboratory staff on the use of rapid kits. The activity will also strengthen military-supported COVID-19 laboratory testing platforms to primarily serve health workers who are more prone to COVID-19.

Description of how this activity is responsive to the category: This allocation will help to scale up testing coverage among health workers and PEPFAR beneficiaries in enclosed settings and enable immediate response to cases identified. Specimens from the 129 prisons are networked to KEMRI and national public health labs for testing. The long distances and turnaround time, and shortage of kits and PPE, are associated with a delay in testing and receipt of results.

How does this activity support or protect PEPFAR services?: Support will complement existing Ministry of Health COVID-19 testing plans though strategic expansion of testing among uniformed beneficiaries. The military offers essential services in protecting and defending the territorial borders of the country. As such, they are at risk of contracting COVID-19 infection in the line of duty in the areas of deployment and in the barracks where they carry out group activities. There is need to increase SARS-COV2 testing coverage as well as enhance the existing IPC systems to ensure the military personnel are protected and safe to carry out their primary duty during the pandemic.

What is the timing to implement and complete this activity? This activity will be completed in FY22 with a possibility of an early start in FY21.

Relevant estimated targets: N/A

Impact statement: Rapid testing and isolation of infectious cases is needed within special populations like the military and prisons to reduce transmission among health workers, PEPFAR beneficiaries, and neighboring communities. The long turnaround time and shortage of kits and PPE are associated with a delay in PCR testing. There is lack of evidence of the burden of COVID-19 among PEPFAR beneficiaries in these settings.

Gap this fills: Congestion in prison, COVID-19 outbreaks with high positivity rates, and a lack of PPE pose substantial risks of transmission within and across prisons as well as in associated communities. This has negatively impacted TB screening and HIV testing and screening and management of other common conditions. Access to COVID-19 testing to facilitate case management at the frontline is not optimal.

Non duplication and coordination statement: Kenya Defense Forces and Kenya prisons' COVID-19 response is coordinated through a TWG that includes development and implementing partners. This has facilitated resource mapping to reduce duplication and maximize synergies. Meetings are held monthly to review progress, identify gaps, and develop mitigation measures. This request will complement what is already provided by other partners.

- Surveillance – Data Improvement

Description of activity: The funding amount requested for this activity is $550,000. Although the 1.5 million PLHIV in Kenya constitute a large population at increased risk for poor COVID-19 health outcomes, counties do not routinely report on COVID-19 testing or health outcomes among PLHIV. This activity aims to: 1) improve routine capture of HIV status and other co-morbid conditions (e.g. diabetes, hypertension) on existing Ministry of Health COVID-19 case investigation forms in all PEPFAR-supported counties; 2) support all PEPFAR counties to use data on HIV status to report on COVID-19 test positivity, attack rates, case fatality rates, and severe outcomes among PLHIV; and 3) use HIV/COVID-19 situational reports to target COVID-19-related health interventions among PLHIV served by the PEPFAR program (e.g. outreach/messaging around health benefits of vaccine, masking/observing social distancing, sustained ART, enhanced clinical management of PLHIV with other co-morbid conditions, etc.). Funds will support rapid assessment of the quality of data collected in the standardized Ministry of Health COVID-19 case investigation tool, with particular focus on completion of the HIV and other co-morbidities fields. Funds will also go to conduct training and capacity-building for improved collection of routine data on PLHIV tested for COVID-19 at county- and site-levels, and technical support to all PEPFAR-supported county governments and PEPFAR partners to analyze and use these data for public health response.

Description of how this activity is responsive to the category: This activity will provide routinely-collected data to measure the public health impact of COVID-19 on PLHIV served by the PEPFAR program and inform strategies for program repair through: 1) improved

collection and use of data on HIV-status and other co-morbid conditions captured on standardized Ministry of Health tools for COVID-19 testing and case investigations; 2) improved use of HIV-status in county-level COVID-19 situational reports on attack rates, tests, positivity, severe outcomes and deaths; and 3) improved capacity to use data to plan and prioritize public health interventions such as COVID-19 vaccinations and messaging among PLHIV served by PEPFAR programs.

How does this activity support or protect PEPFAR services?: This activity will address critical blind-spots in strategic information required to effectively measure and mitigate the burden of COVID-19 infections and outcomes among PLHIV with and without other co-morbid conditions in PEPFAR supported counties.

What is the timing to implement and complete this activity?: This activity will be implemented over 12 months.

Relevant estimated targets: N/A

Impact statement: This activity will directly improve the completeness of data collected on HIV-status and other co-morbidities in existing standardized Ministry of Health tools in the course of routine COVID-19 testing and case investigations in all PEPFAR-supported counties. It will improve county-level capacity to use data on HIV status to estimate and monitor the burden of COVID-19 infections and outcomes among PLHIV with and without other co-morbidities. These data are essential to effectively measure and monitor the public health impact (e.g. in terms of lives lost and severe health outcomes caused by COVID-19 among PLHIV in Kenya) and to develop, prioritize, and monitor the impact of public health response plans focused on preventing and mitigating the health impacts of COVID-19 on PLHIV served by PEPFAR program. The impact of this activity will be directly measured through ongoing monitoring of 1) data completeness around HIV status and other co-morbid conditions; 2) use of HIV status in county-level COVID-19 situational reports on attack rates, tests, positivity, severe outcomes and deaths; and 3) evidence of the use of these data to plan and prioritize public health interventions among PLHIV in PEPFAR supported counties.

Gap this fills: County governments have requested support and technical assistance from CDC-Kenya across these areas.

Non duplication and coordination statement: This is a unique proposal to improve the quality and utility of routinely-collected COVID-19-related epidemiological data on HIV and other co-morbid conditions among PLHIV served by the PEPFAR Kenya program. There are no other known activities supported by other funders within the proposed scope.

CATEGORY II: Mitigate COVID-19 impact on PEPFAR programs and beneficiaries and support PEPFAR program recovery from the impacts of coronavirus

2A Extraordinary logistics and commodity costs to HIV programs associated with COVID-19

Description of activity: The request for these twin activities is $1,450,219. The activities are designed to enhance national supply chain end-to-end data visibility and improve last mile logistics for commodity distribution. Enhancing end-to-end commodity data visibility will involve strengthening commodity data acquisition, improving reporting, and supporting visualization and utilization of this data through appropriate dashboards. Last mile logistics will be strengthened through network optimization and implementation of an electronic proof of delivery system to reduce distribution turnaround time and improve accountability

Description of how this activity is responsive to the category: These twin activities address extraordinary commodity logistics challenges and are one-off interventions to mitigate the effects of COVID-19 on the supply chain and improve overall efficiency of the system. Challenges in timely availability of commodity data and poor reporting due to utilization of manual records have constrained planning and monitoring of the supply chain. Implementing a national integrated system will facilitate end-to end visibility of the supply chain and enhance management decision-making at all levels. Improving last mile logistics will improve efficiency of the supply chain, ensuring timely availability of required commodities at site level.

How does this activity support or protect PEPFAR services?: Commodity security is a critical prerequisite in implementing key PEPFAR program initiatives such as scale-up of 3-month or 6-month multi-month dispensing (MMD), decentralized drug distribution (DDD) models, treatment optimization, and overall attainment of testing, treatment, and other targets that are commodity-dependent. In addition, scale-up of MMD and DDD models are expected to reduce patient clinic visits and overcrowding at facilities thus reducing the risk of transmission of COVID-19. The proposed activities will facilitate timely availability of required commodities at all levels including decentralized distribution sites

What is the timing to implement and complete this activity?: The activity will be implemented in FY22.

Relevant estimated targets: N/A

Impact statement: Implementation of the proposed activities aimed at improving efficiency of the supply chain and overall commodity security are expected to impact multiple PEPFAR initiatives including scale-up of MMD, DDD, and treatment optimization. Successful implementation of these patient-centered initiatives will positively impact several PEPFAR program areas and priorities including treatment continuity, better adherence, and improved viral suppression, and ultimately speed up progress toward epidemic control. These activities are expected to contribute to mitigating the spread of COVID-19 by reducing patient-clinic visits, exposure, and overcrowding at facilities. Monitoring and evaluation plans will cover both the primary and secondary impact of the activities. This will include primary supply chain-related impact such as commodity availability and reduced stock-outs, order turnaround times, and order fill rates. Secondary impact will be measured indirectly through attribution and will include MMD scale-up, retention, and overall VL suppression.

Gap this fills: These activities will complement host government efforts to improve commodity data acquisition and use, as well as optimize commodity distribution networks. Over the years, GoK has worked on improving commodity data management and implementation of these activities will support timely acquisition, reporting, and use of commodity data for decision-making. Last mile distribution activities will support on-going GoK efforts towards decentralization of distribution points and downward referral aimed at improving access to services

Non duplication and coordination statement: These activities are not duplicative and will complement on-going initiatives by GoK and other stakeholders to improve supply chain systems. Current efforts by GoK and GF are focused on improving the overall supply chain framework in the country, strengthening capacity for health commodity management at facility level, and addressing accountability gaps. This investment will focus on health system strengthening for the supply chain sites supported by PEPFAR, with the COVID-related commodities linked to these sites being supported through GF.

2B Laboratory

Description of activity: The request for this activity is $2,726,353. This request is on behalf of four sub-activities designed to strengthen laboratory systems in the face of COVID-19. The VL/EID laboratories have complemented COVID-19 testing. The activity aims to enhance cold chain storage capacity and enhance waste management in PEPFAR-supported labs. It has become necessary to provide additional trainings on testing procedures, QA, and biosafety to support equipment multiplexing for HIV/TB/SARS-COV2. The funding will enhance HRH support through additional level of effort (LOE) to ensure seamless testing services and timely return of results.

Description of how this activity is responsive to the category: The one-off activity will address the unprecedented challenges of cold chain storage, waste management, turnaround time, and testing personnel. Dual platform uses in PEPFAR-supported labs have put constraints on the cold chain storage capacity and waste management for samples, and have additional need of ancillary equipment. The activity will lead to efficient operations in the labs and enhance personnel safety. Multiplexing is a relatively new concept which requires refresher trainings on testing procedures and QA to improve personnel competency and quality of results. Improving ICT infrastructure will enhance timely delivery of results while HRH support will address the additional workload through enhanced LOE. The activity will enhance POC VL and DBC testing so that continuity of services is ensured and targets are met.

How does this activity support or protect PEPFAR services?: Strengthened lab services are critical to PEPFAR to ensure timely availability of testing services for VL and EID. PEPFAR-supported labs have complemented COVID-19 testing, putting extra pressure on the infrastructure and manpower. The proposed one-off activity support will facilitate availability of timely testing services and an efficient return of both HIV and COVID-19 results to the clinicians. The support will enhance safety to lab personnel who are at a higher risk of infection during specimen handling in the labs. It will also support

procurement of additional POC VL and DBS VL testing commodities to mitigate against stock outs.

What is the timing to implement and complete this activity?: The activity will be implemented in FY 22

Relevant estimated targets: N/A

Impact statement: Implementation of the proposed activity aims at improving efficiency in the laboratory network and overall quality of results for VL and EID that are critical to PEPFAR programs. Adequate infrastructure to support sample storage and safe waste management practices ensures integrity of the results and protects the environment. Personnel competency remains an adjunct to quality of results for improved case management of patients at the clinic level. This can only be achieved through timely return of results, access to testing services, and continuous monitoring through an improved data flow system. Additional LOE is instrumental to maintain access to HIV testing services and improve coverage for VL and EID and ultimately achieve the third 95.

Gap this fills: These activities will complement host government efforts towards optimizing existing laboratory capacity through multiplexing. GoK is utilizing existing capacity for SARS-COV2 testing through procurement of commodities required for testing. Additionally, the host government has been central at coordinating VL/EID and SARS-COV2 testing on PEPFAR platforms. The activity will bring visibility to commodity inventory to help ease the intermittent shortages experienced in FY20. The activity will also ensure continuity of POC VL and DBS VL services and meeting of existing targets.

Non duplication and coordination statement: These activities are not duplicative and will complement on-going initiatives by the GoK and other stakeholders to improve laboratory systems. Current efforts by the GoK and GF are focused on procurement of testing reagents and IPC materials. PEPFAR support will be in instrumental in addressing the gaps in the lab systems that currently exist.

2C "Repair of Program Injury" i.e., support for PEPFAR programmatic acceleration and recovery from adverse impacts on PEPFAR program performance due to COVID-19.

- Community Interventions – Continuity of Treatment

Description of activity: This activity requests $400,000 to support client-centered innovations for enhanced adherence and continuity of treatment with a focus on expanded DSD models including MMD, DDD, and case management. This will be implemented through: 1) peer-to-peer drug distribution channels; 2) community ART pick up points; and 3) enhanced community ART groups among experienced and stable recipients of care through psychosocial support systems to minimize treatment interruption among recipients of care and enhance retention.

Description of how this activity is responsive to the category: The PEPFAR Kenya program experienced major challenges due to COVID-19 travel restrictions as well as IPC requirements. Partial lockdown of the country with subsequent job losses and relocation of beneficiaries to rural regions resulted in limited access to ART clinics and led to treatment interruptions among clients. COVID-19 public health restrictions further impacted critical program activities including psychosocial group meetings, physical tracking, and tracing efforts. Funding allocation for this activity will help toward addressing gaps exacerbated by COVID-19 and mitigating treatment interruptions among recipients of care with the aim of improving treatment continuity and suppression.

How does this activity support or protect PEPFAR services?: The activity complements existing efforts toward bridging the gaps emanating from the negative pressure of COVID-19 on the program through the expansion of DSD models, DDD, and case management approaches. The resources will be used to expand client community drug delivery points including: 1) community mobile dispensing points; 2) collaboration with private chemists to act as pick up points; and 3) logistic support to CHWs for drug distribution in communities (bicycles, drug backpacks, packaging materials, and transport reimbursement where appropriate). Funding will go toward supporting additional clinics in provision of flexi- or extended hours for improved access to ART services.

What is the timing to implement and complete this activity?: This activity will be completed during FY21 through FY22.

Relevant estimated targets: Linkage rate = >95%; Retention = 98%.

Impact statement: Continuity of treatment is critical for maintaining the health of PLHIV and achieving epidemic control and is attainable through client-centered approaches. Efforts geared at re-engagement of recipients of care back to treatment are a priority to improve clinical outcomes across the cascade. Scaling up of DSD models including MMD and DDD and strengthening of clinic appointment systems will help address gaps in treatment continuity. These activities will complement other public health measures seeking the decongestion of clinics as a measure to reduce COVID-19 transmission and will relieve the human resource constraints at the clinics related to COVID-19 pandemic.

Gap this fills: COVID-19 restrictions have impacted HIV programming negatively and contributed to treatment interruptions among recipients of care. Travel restrictions, fear of being infected at the facilities, and stigma associated with COVID-19 have led to low clinic attendance and act as a barrier to access HIV services.

Non-duplication and coordination statement: Adherence and continuity of treatment, as well as viral suppression, are top priorities of both PEPFAR and Ministry of Health and the efforts supported through this funding will be complementary mainly towards mitigating the negative impact of the COVID-19 pandemic on the HIV program.

- Community Interventions – Case Finding

Description of activity: This activity requests $1,040,000 to accelerate distribution of HIVST kits among underserved key and vulnerable populations through direct targeting using peer educators as well as linkage to HIV treatment and prevention services.

Description of how this activity is responsive to the category: One of the pillars of the COVID-19 response is minimizing interruption of services. COVID-19 has resulted in a reduction in case identification. There is the need to accelerate case identification and linkage to HIV treatment and prevention services to close the gaps that resulted in facility-based service delivery interruption, thus slowing down progress towards epidemic control. This activity will enhance linkage and follow up of clients who receive HIVST, as well referral for other HIV prevention services (e.g. PrEP and VMMC)

How does this activity support or protect PEPFAR services?: A key goal of PEPAFR services is to grow the cohort of patients receiving high quality HIV treatment services. COVID-19 disrupted case identification and scale up of HIVST due to movement restrictions and fear of visiting health facilities for services. Additionally, linkage to treatment services was also affected. This activity aims to close the gaps brought about by interruption of services and accelerate knowledge of HIV status, case identification, and linkage to treatment, as well as HIV prevention services.

What is the timing to implement and complete this activity?: These activities will be implemented as soon as the funds are availed.

Relevant estimated targets: N/A

Impact statement: This activity is expected to impact the PEPFAR program by accelerating knowledge of HIV status, linkage to treatment, and prevention services. Engagement at community level will provide an opportunity to pass key information about HIV treatment and prevention, while providing HIVST and referral to services. This will support Kenya's journey towards epidemic control through increased initiation to treatment of persons diagnosed with HIV as well as uptake of HIV prevention services. By providing more convenient access to HIV commodities in the community, this activity will contribute to reduced movement of persons and decongestion at health facilities, hence reducing the rate of transmission of COVID-19.

Gap this fills: One of the key goals of the Ministry of Health COVID-19 response is to ensure continuity of health services, while minimizing the risk of COVID-19 transmission. While most efforts have focused on continuity of facility-based health services, there have been minimal investments in community services. This activity will complement GoK efforts to ensure continuity of HIV services as the country continues moving towards its goal of achieving epidemic control.

Non duplication and coordination statement: The GF support is expected to procure commodities for program recovery. This activity focuses on community distribution of HIVST and follow up for referral for linkage to HIV treatment and prevention services to ensure continuity.

- Prevention Programming (GBV, AGYW, KPs, PrEP, Staffing, and Prisons)

Description of activity: This activity requests $1,650,000 to support demand creation through mass and social media as alternatives to in-person community campaigns that have been discontinued. Funds will support frameworks for virtual provider-client contact for primary service delivery and follow up, as well as boost program capacity to cope with the COVID-19-related increase in GBV and economic vulnerability among AGYW and OVC. The funds will also support engagement of temporary personnel to maintain service delivery when regular staff are off duty due to COVID-19 exposure. The resources will also support COVID-19 mitigation measures in the PEPFAR-supported HIV prevention program for prisons. Additionally, resources will be used to support the national campaign for PrEP education and awareness and sustain demand creation in the absence of in-group demand creation and movement restriction due to COVID-19. Specifically, the national mass media campaign is budgeted at $ 500,000 for the nascent PrEP program to sustain momentum for public dialogue on its benefits.

Description of how this activity is responsive to the category: Planned activities will ensure continuity of the much-needed HIV prevention services and associated demand creation while complying with the national guidelines for COVID-19 prevention.

How does this activity support or protect PEPFAR services?: Despite COVID-19, the planned activities will sustain demand creation for service uptake, maintain HIV service delivery, and enhance program capacity to cope with the negative effects of COVID-19 (e.g. increased cases of GBV and socioeconomic vulnerability among PEPFAR program beneficiaries especially AGYW and OVC). This support will also ensure sustained PrEP uptake during the COVID-19 pandemic

What is the timing to implement and complete this activity?: Planed activities will be implemented in FY22

Relevant estimated targets: N/A

Impact statement: Activities will lead to the maintenance and uptake of HIV services, improved quality of HIV services, and continued progress on the 90-90-90 cascade for beneficiaries (key and vulnerable populations and AGYW). COVID-19 infection among PEPFAR program staff and beneficiaries will be kept at a minimum and comparable to national incidence.

Gap this fills: The activities will support compliance with Kenya government guidelines for COVID-19 mitigation in HIV service delivery settings. Activity funding will create a framework for preventing COVID-19 while maintaining critical services to the population. The activity will also mitigate the additional programming operational costs brought about by COVID-19.

Non duplication and coordination statement: This activity is not duplicative with other funding agencies .

- MNCH - PBFW

Description of activity: This activity requests $1,181,746 to support programmatic

acceleration and recovery from adverse impacts on program performance due to COVID-19, with a focus on PBFW and their needs related to retention in care for mother-infant pairs, SGBV, and mental health services.

Description of how this activity is responsive to the category: This activity will provide virtual adherence support for PBFW through SMS reminders and virtual support groups to address mental health issues arising from COVID-19. It will support targeted outreach staff such as mentor mothers and case managers to work remotely.

How does this activity support or protect PEPFAR services?: With restrictions on physical gatherings, some planned MNCH activities have not been done to scale. The curfews have increased cases of SGBV and mental health needs among PBFW. Continued adherence and psychosocial support will address mental health issues arising from COVID-19. Additional mentor mothers will be recruited and a package of additional phones and airtime/mobile data to enable them stay connected with other members of the program support teams and beneficiaries.

What is the timing to implement and complete this activity?: As soon as the funds are approved, the majority of work will be implemented over one year.

Relevant estimated targets: N/A

Impact statement: PBFW will be supported to attend virtual support groups whenever they are unable to access facility services. They will also receive SMS reminders. A virtual adherence system will be established or strengthened in all PEPFAR-supported sites. CHVs will be supported with airtime and bundles to contact PBFW and remind them to take their medicine and to provide adherence support.

Gap this fills: Capacity building, airtime, SMS messaging, and virtual support will be provided to CHVs to be able to address adherence and mental health issues arising from COVID-19. This will complement existing protocol on physical gatherings and ensure continuity of services for clients

Non duplication and coordination statement: Neither Global Fund nor ongoing or planned USG COVID-19 response activities are duplicative with this activity.

- Cervical Cancer

Description of activity: PEPFAR Kenya requests $ 606,667 for this activity. Funds will be used to implement the use of HPV self-sampling for HPV testing, to mitigate the observed negative impact of COVID-19 on cervical cancer screening programs funded through the PEPFAR Go Further initiative. Self-sampling would reduce the time women may be exposed to COVID-19 while attending clinics in person, enabling women to collect a sample for HPV testing in the privacy of their home.

Description of how this activity is responsive to the category: One clear immediate negative impact that COVID-19 has had on PEPFAR programs in Kenya is the dramatic decrease in the number of women who accessed cervical cancer screening services supported by the PEPFAR Go Further initiative. Data from the PEPFAR show that, in nearly all counties in Kenya, the number of HIV-positive women on ART screened for cervical

cancer dropped by more than half between 2019 Q2 and 2020 Q4. The reasons for this dramatic decrease likely includes COVID-19-related restrictions in movement, transport, reduction in clinic services (especially during COVID-19 surges), and fear of attending clinics in person.

How does this activity support or protect PEPFAR services?: Home-based HPV self-sampling has been shown to increase participation in cervical cancer screening and effectiveness of screening. Self-sampling also has been shown to be a convenient and cost-effective method to increase screening participation among hard-to-reach women. The activity will also lay the groundwork to prepare for the scale up of cervical cancer screening using HPV testing that has shown to have higher precision than using VIA to identify women at high risk for cervical cancer in Kenya.

What is the timing to implement and complete this activity?: This activity will be implemented and completed during COP21

Relevant estimated targets: 20,000 women 25-49 years

Impact statement: PEPFAR Kenya resumed support for cervical cancer screening and treatment; however, the resumption has been severely affected by COVID-19. This activity will increase the number of women being screened and treated for cervical cancer (CXCA_SCRN and CXCA_TX) in PEPFAR-supported sites. In addition, the activity will reduce congestion at screening sites reducing probability of COVID-19 exposure and infection. Funds will also be used to support the design of a cervical cancer screening registry using mobile phones to 1) contact women to provide screening results; 2) link to follow-up services; 3) remind women to go for repeat screening; and 4) reduce the number of women lost to follow-up after abnormal screening results, maximizing the number of women linked to appropriate treatment while minimizing exposure to COVID-19 from waiting at the health care facility. All women accessing self-screening will be tracked through the cascade and their outcomes documented then compared to the women screened using the conventional VIA. PEPFAR Kenya will monitor acceptance, number of women offered and accepting HPV self-sampling, number turning positive, number accessing VIA screening, and number treated for cervical dysplasia. Time to each intervention will also be monitored.

Gap this fills: The government has committed to the WHO 90-70-90 goal of cervical cancer elimination by 2030. This includes increasing cervical cancer screening in women of reproductive age and improving access to treatment for those with cervical dysplasia. Currently there is no host government providing support for HPV self-sampling.

Non duplication and coordination statement: PEPFAR Kenya will coordinate with other funding mechanisms supporting COVID funding. PEPFAR Kenya will take part in proposal development for the C19RM Global Fund funds request and will share this proposed work plan and activities with other funding mechanisms.

- Mental Health

Description of activity: The total funds requested for this activity are $1,450,000. The activity will facilitate access to critical mental health support services for PEPFAR-supported health care workers and patients, including vulnerable populations, both at national (HRH Kenya, Ministry of Health, Prisons, Military) and county levels based on the COVID-19 burden and incidence (COVID-19 cases >2,000) in PEPFAR-supported counties (Nairobi, Mombasa, Kiambu, Nakuru, Uasin Gishu, Machakos, Kajiado, Kilifi, Busia, Kisumu, Kericho, Meru).

Description of how this activity is responsive to the category: PEPFAR Kenya supports roughly 25,000 health care workers and over one million HIV patients. While several services are in place to offer mental health support to health care workers at both the national and county level, it is unclear that these services are reaching PEPFAR-supported health care staff. Mental health support for patients is limited. This activity aims to increase awareness of existing services, facilitate access to these services by PEPFAR's health care workers and patients, as well as fill critical gaps in mental health services provided in a sustainable way.

How does this activity support or protect PEPFAR services?: This activity will ensure PEPFAR's health workers and patients have access to critical mental health services as they continue to provide and receive HIV services against the backdrop of the ongoing COVID-19 pandemic. The national IMs will provide policy and coordination support between the national and county governments to support county interventions and develop mental health programs and materials to ensure wide coverage. County lead IPs will work with county teams to establish existing mental health support needs, hire short-term psychologist(s) where necessary, facilitate the provision of existing services, and enable access to the services by the targeted beneficiaries.

What is the timing to implement and complete this activity?: IPs will begin to implement services as soon as funding is available. Because the pandemic is ongoing, this activity will continue into COP21, subject to funds availability.

Relevant estimated targets: N/A

Impact statement: This activity will be implemented in the 12 PEPFAR-supported counties listed above. The lead clinical IPs will facilitate the use of the existing mental health services for health workers and patients at the county level. Working with the Ministry of Health mental health department, national implementing mechanisms (IM), and DOD, as well as county-level mental health workers, each lead IP will identify the services available for their specific county, create communication campaigns to educate health workers and patients on those services, and facilitate access to those services (e.g. hosting forums for county mental health psychologists to speak to health workers and patients; allowing health workers time to seek mental health services). For those counties where mental health services are not available, the lead IP will aim to support the short-term hire of mental health professionals to offer services to health workers and patients. Working with the national IM and the Ministry of Health Department of Mental Health, a tracking system on health workers exposure to COVID-19 and access to mental health services will be implemented.

Gap this fills: This activity aims to work hand in hand within the existing Ministry of Health mental health structures at both national and county levels. A review of the current status for services that are already offered will be done with the aim of identifying gaps, facilitating access to mental health services, and ensuring through engagement with Ministry of Health sustainability of mental health services beyond the currently available support.

Non duplication and coordination statement: Mental health services have not been budgeted for by other funders.

- TB Case Finding

Description of activity: PEPFAR Kenya is requesting $953,333 for this activity. Investments will be made at the facility level to refocus clinicians' efforts beyond COVID-19 to improve processes for TB case finding, including TB and COVID-19 screening, contact tracing, and community TB treatment initiation and follow-up. TB preventative treatment (TPT) and TB treatment MMD will be scaled up beyond the Nairobi pilot projects. Optimal infection prevention and high-level county government commitment will be secured, and TB-specific county health management team (CHMT) support supervision conducted to strengthen TB activities.

Description of how this activity is responsive to the category: Tuberculosis case finding has declined by 25% since the advent of COVID-19 in Kenya. This decline is related to the decrease in out-patient department (OPD) attendance associated with the perceived increased risk of COVID-19, the overlap of TB and COVID-19 symptoms, and the quarantine of suspected COVID-19 cases. This decline has led to many undiagnosed TB cases in the community and related morbidity and mortality, especially among PLHIV. This activity will increase TB case finding

How does this activity support or protect PEPFAR services?: TB is the leading cause of morbidity and mortality among PLHIV, accounting for 1/3 of all TB mortalities. COVID-19 has led to the disruption of TB services, with TB screening most affected. This activity aims to strengthen TB screening at both the facility and community levels. In addition, the activity will scale up TPT and TB MMD, which will protect the TB program against the shocks brought about by COVID-19.

What is the timing to implement and complete this activity? This activity will be implemented in the current COP20.

Relevant estimated targets: N/A

Impact statement: Pre-COVID-19, Kenya had a 60% TB case detection. TB case finding declined 25% from the first COVID-19 case notification, with slight recovery afterward. There is an urgent need to improve case detection to prevent reversal of the gains made over the past two decades while addressing the COVID-19 pandemic within USG-supported programs. Digital solutions are needed to increase reach in case finding, case holding, and optimal TB/COVID-19 treatment outcomes. Lessons learned from CDC pilot projects in Nairobi will be used to support Ministry of Health development and to scale up digital tools

for TB and COVID-19 case-finding, TB case holding, and remote monitoring for optimal treatment outcomes. Adherence to treatment, viral suppression, and continuity of treatment are key priorities of PEPFAR and Ministry of Health in COP20 and into COP21 to achieve HIV epidemic control. TB case finding will be monitored monthly, and it is estimated that this activity will increase TB case finding by 10% relative to FY20 achievements.

Gap this fills: Kenya's COVID-response did not account for TB control at the outset. On the contrary, there was stigmatization of individuals with respiratory symptoms with a resultant decline in OPD attendance and TB case detection. An integrated TB and COVID-19 case finding initiative supported by CHMTs will build on the work done in COVID-19 and TB control to deliver TB and COVID-19 screening to maximize case detection for both diseases.

Non duplication and coordination statement: PEPFAR Kenya will coordinate with other funding mechanisms supporting COVID funding. PEPFAR Kenya will take part in proposal development for the C19RM Global Fund funds request and will share this proposed work plan and activities with other funding mechanisms to avoid duplication.

Summary Table – Full Table in FAST

	Category	Key Intervention	Key Activities	Brief Description of How Support Will be Used	Requested Budget ($)
1A	**IPC**	IPC	Comprehensive IPC implementation at national, site, and special settings (e.g. prisons and military)	**<u>National level</u>** • Review of IPC guidelines and protocols Timely review of training curriculum, capacity building, and mentorship to health workers • Development of e-learning platforms. • National/sub-national level planning and conducting risk assessment for health workers • Development of tools for reporting • Risk communication **<u>Facility level</u>** • *Engineering and Environmental Controls* o Reduce exposure to health workers by placing a barrier between hazard and health worker o Address the basic infrastructure of the health care facility o Adequate ventilation in all areas in the health care facility o Spatial separation of at least 1.5m between Patients. o Adequate WASH infrastructure and environmental cleaning and disinfection o Safe medical waste management o Infrastructure adjustment (e.g. creating sneeze guard barriers, tents) • *Administrative Controls* o Formation of IPC committees o Capacity building and mentorship on IPC, guidelines, and SOPs o IEC materials to the sites o Patient triaging of both general patients and COVID suspects (triage algorithm). o Monitoring health worker compliance, cohort health workers and patients • *Risk-Based PPE* o Risk-based PPE to health workers and patients	3,842,500
				• Quarantine facilities will be expanded and "green zones" created for protection of the elderly and other vulnerable individuals • Prison wards will be renovated, tents supplied, and capacity of the Kenya prisons industry built for sustainable in-house production of reusable masks	400,000

2C	**Program Injury**	Community Interventions	Continuity of treatment: expanded DSD and community ART distribution	• Expand client community drug delivery points including community mobile dispensing points • Collaborate with private chemists to act as pick up points and provide logistic support to CHWs for drug distribution at community level (bicycles, drug backpacks, packaging materials, and transport reimbursement where appropriate). • Support additional clinics in provision of flexi- or extended hours towards improving access to ART services.	400,000
			Improved case finding: HIVST community distribution by peer educators	• Support peer educators linked to facilities to distribute the HIVST in the community, as well provide information on linkage to treatment and prevention services.	1,040,000
		Economic Strengthening	Economic strengthening: AGYW	• Support economic strengthening for highly-vulnerable households (target caregivers and AGYW, including community health volunteers, ambassadors, and mentors), including provision of a group-based business start-up kit for skill-based training to scale up production of reusable masks, soap, detergent etc.	200,000
2B	**Lab**	Lab	Enhanced lab testing for COVID/HIV/TB with improved capacity and safety	• Enhanced POC VL and DBS testing	256,353
				• One-off procurement of storage and waste management equipment within PEPFAR supported labs (freezers and autoclaves) and additional ancillary equipment.	870,000
				• Additional trainings (testing procedures, QA, biosafety, etc.) for equipment multiplexing for HIV/TB/SARS-COV2	600,000
				• Improvement of supportive communication infrastructure, e.g. internet, servers, computer systems, and general M&E tools	500,000
				• Expansion of lab HRH and additional LOE during the pandemic	500,000
1C	**Testing**	Testing	Enhanced testing in special settings	• Procure rapid antigen test kits and train uniformed laboratory staff on use of the kits • Strengthen military-supported COVID-19 laboratory testing platforms to serve the health workers that have been more prone to getting infected with COVID-19 when caring for PLHIV; provide confirmatory testing in the event of inconclusive results on the COBAS 8800 or GeneXpert systems	500,000

2C	**Program Injury**	GBV	GBV support	• Respond to increased GBV cases by expanding service access beyond the 8-hour work day • Support debriefing among service providers for psychosocial support • Use multiple platforms to increase mobilization for prevention, response, support, and mitigation of GBV impacts including setting up rescue centers	600,000
		Cervical Cancer	HPV self-sampling at home for cervical cancer screening	• Implement the use of HPV self-sampling for HPV testing, as a way to mitigate the observed negative impact of COVID-19 on cervical cancer screening programs funded through the PEPFAR Go Further initiative • Support the design of a cervical cancer screening registry using mobile phones to contact women to: 1) provide screening results; 2) link to follow-up services; 3) provide reminders for repeat screening; 4) reduce the number of women lost to follow-up after abnormal screening result.	606,667
		Prisons	Isolation corners in prisons and linkages to care	• Set up COVID isolation corners in prisons and support linkage of infected prisoners to clinical care	400,000
		Mental health	Mental health support	• Provide mental health support to health workers	1,450,000
2A	**Supply chain**	Supply chain	Supply chain and logistics	• Support planning and monitoring of the supply chain through enhanced supply chain data visibility (end-to-end visibility)	1,000,000
				• Support strengthening of last mile logistics for commodity distribution	450,219
				• Provide COVID-19 supply chains systems strengthening assistance to Ministry of Health and counties through the Council of Governors to address current constraints to real-time tracking of COVID-19 commodities in the entire supply chain (including supply chain process redesign to enable visibility, real-time tracking, and accountability of COVID-19, HIV/AIDS, TB, and malaria commodities along the chain through an automated control tower system)	1,000,000
1C	**Surveillance**	Surveillance	Surveillance	• Improve routine capture of HIV status and other co-morbid conditions (e.g. diabetes, hypertension) in the course of COVID-19 testing and case investigations in all PEPFAR-supported counties • Support all PEPFAR counties to use data on HIV status to report on COVID-19 test positivity, attack rates, case fatality rates, and severe outcomes among PLHIV • Use HIV/COVID-19 situational reports to target COVID-19-related health interventions among PLHIV served by PEPFAR program	500,000
				• Use routinely-collected VL remnant specimens to monitor COVID-19 exposure, vaccination coverage, and overall herd immunity among PLHIV in Kenya using serologic testing for SARS-COV2 infection	550,000

2C	**2C Program Injury**	TB Case Finding	TB case finding and bidirectional screening	• Improve processes for TB case finding, including bidirectional TB and COVID-19 screening, reverse and routine contact tracing, and community TB treatment initiation and follow-up • Scale up of TPT and TB treatment MMD beyond the Nairobi pilot projects • Secure high-level county government commitment • Optimal infection prevention for COVID-19 and TB in the TB clinics in PEPFAR-supported facilities. • Conduct TB-specific CHMT support supervision at all service delivery points • Develop, disseminate and scale-up digital solutions for TB/COVID-19 screening, linkage to care, adherence support, and adverse effect monitoring	953,333
		Staffing	Temporary staff during quarantine / isolation	• Support engagement of temporary staff to replace those on quarantine due to COVID-19 exposure	150,000
		Virtual Services	KP engagement	• Facilitate virtual peer educator sessions and referrals • Facilitate virtual appointments and client-clinic management follow up	300,000
			PBFW	• Virtual adherence support for PBFW through SMS reminders and virtual support groups to address mental health issues arising from COVID-19 • Supporting targeted outreach staff such as mentor mothers and case managers to work remotely	1,181,746
				TOTAL	**18,250,599**